State of Maryland

Drug Treatment Task Force Final Report

BLUEPRINT FOR CHANGE: Expanding Access to and Increasing the Effectiveness of Maryland's Drug and Alcohol Treatment System

February, 2001

Lt. Governor Kathleen Kennedy Townsend, Chair
Delegate Dan Morhaim, M.D., Vice Chair

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DRUG TREATMENT TASK FORCE//
FINAL REPORT//

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STATE OF MARYLAND
TASK FORCE ON DRUG TREATMENT

OFFICE OF THE LT. GOVERNOR
STATE HOUSE, 100 STATE CIRCLE
ANNAPOLIS, MD 21401

February 6, 2001

Dear Governor Glendening and Members of the General Assembly:

Thank you for your leadership on drug and alcohol treatment. As you know, we are making real strides to increase the amount we invest in drug treatment. But there is more to be done. The Maryland Drug Treatment Task Force held public hearings throughout the state to better understand the scope of the problem and hundreds of individuals turned out to tell their stories.

This report presents the findings and recommendations of the Maryland Drug Treatment Task Force. The recommendations seek to fulfill two goals: expanding access to drug and alcohol treatment and increasing the effectiveness of treatment.

Addiction is one of the most complicated and far-reaching challenges Maryland faces today. For too long, drugs and alcohol have ravaged the lives of our citizens. By working together, we have an opportunity to help individuals who are struggling with addiction reclaim their lives and return to healthier families and safer communities.

Thank you for your support. We look forward continuing to work with you on this important issue.

Sincerely,

Kathleen Kennedy Townsend
Lt. Governor Kathleen Kennedy Townsend
Chair

Dan K. Morhaim
Delegate Dan Morhaim, M.D.
Vice Chair

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EXECUTIVE SUMMARY

This report presents the findings and recommendations of the Maryland Drug Treatment Task Force. The recommendations seek to fulfill two goals: expanding access to drug and alcohol treatment and increasing the effectiveness of treatment.

Drug and alcohol addiction in Maryland destroys lives, shatters families, and drains public resources. Last year, at least one person a day died of a drug overdose in Baltimore City. 60% of child welfare cases and 72% of all child out-of-home placements in Maryland involve parental substance abuse, according to a study by the Child Welfare League of America. The Center for Substance Abuse Research has estimated that addiction and its consequences (such as crime, job absenteeism, and health care) cost Maryland $5.5 billion each year, and the State only provides treatment to approximately 30% of those needing treatment. This report looks at these problems and presents specific recommendations to increase access to drug and alcohol treatment and improve its effectiveness.

The Maryland Drug Treatment Task Force held public hearings throughout the state to better understand the scope of the problem. Hundreds of individuals turned out to tell their stories. The members of the Task Force learned more about the horrors of addiction: the desperation, lost children, and broken communities. But they also heard about the triumph of treatment when it is available: reunited families, reformed neighborhoods, and reclaimed lives.

This report sets out two goals:

1. **Expanding access to drug treatment in Maryland.**

2. **Increasing the effectiveness of that treatment.**

To achieve the goal of expanding access to treatment, the Task Force makes the following recommendations:

- ***Increasing baseline drug and alcohol treatment system funding by at least an additional $300 million over the next ten years.*** The funding would come from both public and private sources such as private health insurance. Increases would include funding for operational and capital expansion.

- ***Pursuing meaningful implementation of parity for drug and alcohol treatment services covered by private health insurance.*** State law requires private health insurers who offer drug and alcohol treatment coverage to cover it the same as other medical treatments. Full implementation of this law will help ensure that the private sector is contributing its share of treatment resources.

- ***Implementing recommendations made by the Medicaid Drug Treatment Work Group to improve Medicaid coverage of treatment services.*** Since the implementation of HealthChoice, Maryland's Medicaid managed care program, there has been an overall reduction in drug treatment service delivery. The Substance Abuse Improvement

Initiative developed by the Medicaid Drug Treatment Workgroup seeks to reverse this trend and increase access to drug and alcohol treatment services for HealthChoice enrollees.

To achieve the goal of increasing the effectiveness of drug and alcohol treatment, the Task Force makes the following recommendations:

- ***Increasing salaries for all public drug and alcohol treatment system employees.*** Low salaries make it difficult for treatment programs to hire and retain trained and experienced employees, resulting in a high turnover rate. These workforce issues reduce the treatment system's capacity and its ability to deliver the most effective treatment. Trained and experienced staff is an essential component of a treatment system that produces the best possible results.

- ***Implementing a statewide performance measurement system for the drug and alcohol treatment system.*** The Task Force recommends evaluating information from drug and alcohol treatment programs and reviewing specific program indicators on an annual basis. This will enable Maryland to improve the management of the treatment system and the quality of services. Performance measurement will also increase public confidence in the effectiveness of treatment and bolster support for additional investments.

- ***Creating a Drug and Alcohol Council to coordinate drug and alcohol treatment activities and funding across State agencies.*** Maryland's alcohol and drug treatment system is becoming more sophisticated and complex. It serves clients involved in a variety of public systems, including health, welfare, child welfare, and criminal and juvenile justice. An elevated level of statewide coordination would improve the drug and alcohol treatment system's ability to deliver effective services.

This report is the result of two years of work. The recommendations reflect consensus and extensive public input. Putting those recommendations into practice will move Maryland closer to a treatment system that treats every addict who requests help with the best, most cutting-edge services available. The work to expand access to drug and alcohol treatment and increase its effectiveness is not finished. Task Force members look forward to working with the State and localities to achieve these vital long-term goals.

I. INTRODUCTION

As Maryland's Governor, Lt. Governor, and General Assembly have recognized, drug treatment is a wise investment for government and society because it decreases drug use, crime, welfare dependence, child welfare and health care costs, and increases employment and social well-being. As a result of significant support for expanding and improving drug and alcohol treatment services, the General Assembly passed legislation in 1998 (House Bill 149, Introduced by Delegates Morhaim and Nathan-Pulliam; See Appendix A) establishing the Task Force to Study Increasing the Availability of Substance Abuse Programs, otherwise known as the Drug Treatment Task Force. The objective of the Task Force, as directed by the legislature, is to develop a strategy for increasing the funding and the availability of substance abuse programs in the State. This report represents the Task Force's recommendations on these issues.

The Task Force is chaired by Lt. Governor Kathleen Kennedy Townsend and vice chaired by Delegate Dan Morhaim. Its two committees, Treatment Availability and Treatment Effectiveness, focus specifically on treatment financing, special populations, treatment system infrastructure and performance measurement. The Availability Committee is chaired by Jude Boyer-Patrick, M.D., MPH, and the Effectiveness Committee is co-chaired by Peter Luongo, Ph.D. and Delegate Shirley Nathan Pulliam. These committees include additional participants beyond official Task Force membership that represent the breadth of the community interested in drug and alcohol treatment issues. Members include treatment providers, consumers, family members, foundation officials, state and local government officials, researchers, treatment policy experts, physicians, hospitals, advocates and members of the General Assembly. The membership lists for these committees can be found in Appendix B.

The committees each have jurisdiction over a discrete set of issues. The Availability Committee is responsible for reviewing the financing of drug and alcohol treatment services and the needs of selected special populations. The Effectiveness Committee is responsible for overseeing the development of improved drug and alcohol treatment system infrastructure, including the development of a treatment accountability system that will measure treatment outcomes and program performance.

The work of the Task Force has required close collaboration with several state agencies, including the Alcohol and Drug Abuse Administration, Medicaid, the Department of Human Resources, and the Department of Public Safety and Correctional Services, and the Department of Juvenile Justice. These agencies have provided information and expertise to the Task Force as its committees have reviewed various issues and sought to increase statewide coordination of treatment funding and services.

The Task Force also has engaged significant community participation throughout the process of reviewing Maryland's drug and alcohol treatment system. Activities involving community participation included:

- **Regular Full Task Force Meetings**

  Attendance at full Task Force meetings, held every 10-12 weeks, has steadily escalated with 50-100 individuals attending the last several meetings. The Task Force has encouraged active participation by the general public.

❖ **Treatment Availability and Effectiveness Committee Meetings**

Attendance at regular committee meetings, held every 2-3 weeks, has escalated to approximately 20-25 individuals at each meeting, with members taking an active role in researching and shaping the final recommendations by investigating issues and vetting recommendations with the broad constituencies they represent.

❖ **The Treatment System Needs Assessment**

Last February, the Task Force conducted a needs assessment of the drug and alcohol treatment needs of each of the 24 jurisdictions in Maryland (Appendix C). The needs assessment was based on a series of focus groups and interviews conducted with county Health Officers, Addictions Treatment Coordinators, a variety of treatment providers, and individuals.

❖ **Regional Public Hearings**

Last spring, the Task Force held four public hearings throughout the State to collect information from local communities about the drug and alcohol addiction and treatment issues in their region. (Hearing flyer, Appendix D). These hearings were extremely successful, with over 550 individuals attending and over 150 persons testifying. Hearings were held in Baltimore City, College Park, Salisbury and Hagerstown. A broad range of individuals testified at these hearings, including persons in treatment, persons in recovery, treatment providers, parents, local community leaders, ministers, educators, charitable foundations, prevention organizations, advocates, and legislators.

❖ **Performance Measurement Meetings and Correspondence**

Task Force staff and Committee members conducted special meetings with specific groups in the treatment community across the State to discuss the development of the performance measurement system. Meeting participants included drug and alcohol treatment providers, County Addictions Treatment Coordinators, and regional representatives of the treatment provider community. Over 200 individuals were consulted through this process.

Additionally, the Task Force sent out two reports on the development of the performance measurement system for review by all certified drug and alcohol treatment programs throughout the State. The Task Force corresponded with over 350 programs through this process.

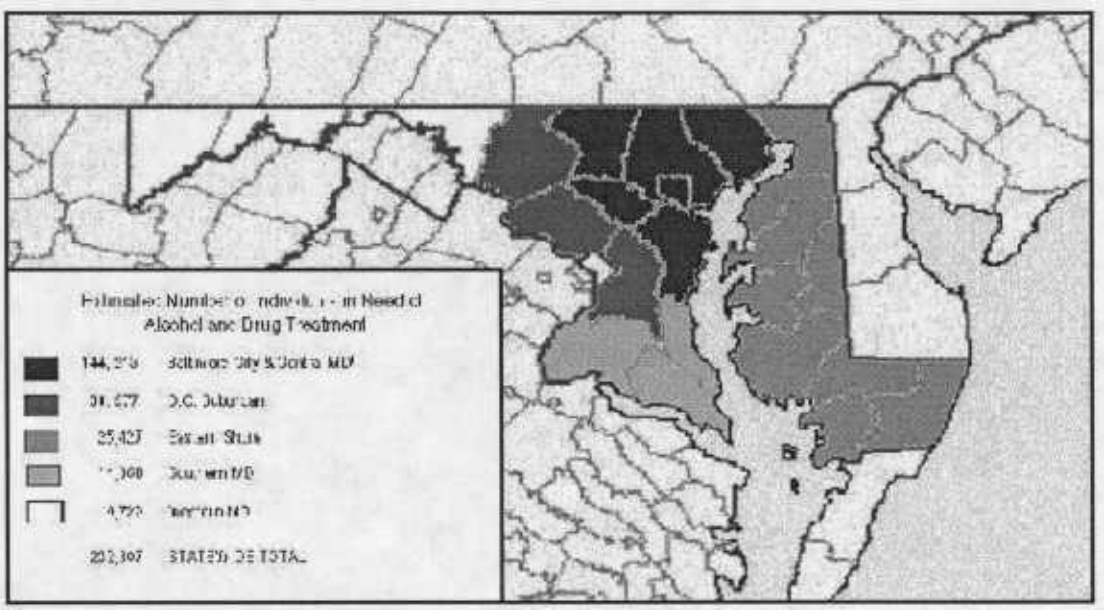
❖ **Medicaid Drug Treatment Workgroup**

To work through problems related to the delivery of drug and alcohol treatment by the HealthChoice program, the Drug Treatment Task Force requested that the Department of Health and Mental Hygiene convene a workgroup consisting of Medicaid/HealthChoice staff, members of the Task Force, Managed Care Organization representatives, drug and alcohol treatment providers, and other drug and alcohol treatment or health care financing experts. This workgroup met regularly throughout the fall to review problems related to the delivery of drug and alcohol treatment services under the HealthChoice program and crafted the HealthChoice Substance Abuse Improvement Initiative presently underway. This workgroup will continue to meet over the next several months to develop an evaluation of the Substance Abuse Improvement Initiative and the carve out model for drug treatment services that will be implemented if the Improvement Initiative proves to be unsuccessful.

II. MARYLAND'S ADDICTION AND TREATMENT SYSTEM PROFILE

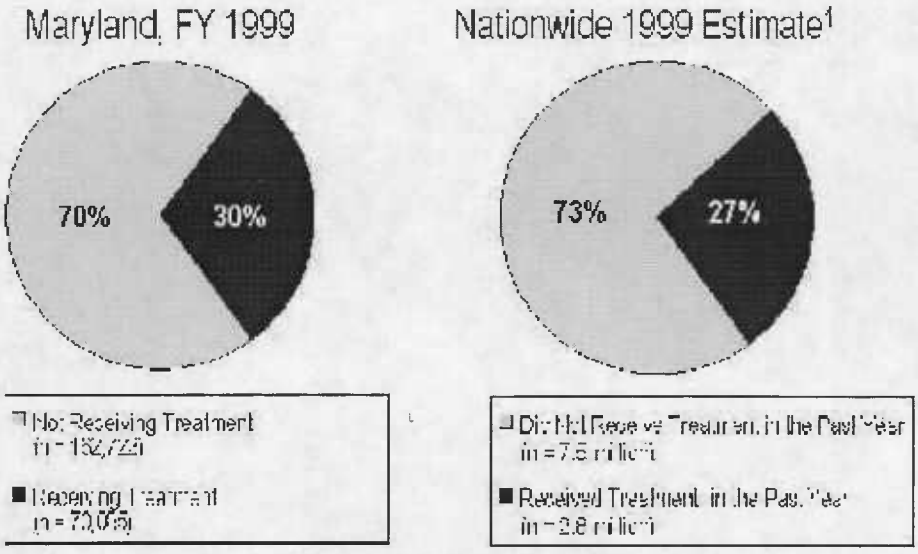
In FY 99, the estimated number of individuals in need of alcohol and drug treatment in Maryland was 232,807[2]. As Figure 1 illustrates, the need for treatment varies throughout the state. During FY 99, Maryland served 30% of the individuals needing treatment[3], while nationally only 27% of the persons who need treatment receive it[4] (Figure 2). 70% of the individuals who received treatment in Maryland during FY 99 accessed publicly funded treatment[5]. (Figure 3)

Figure 1: Current Need for Alcohol and Drug Treatment in Maryland by Region



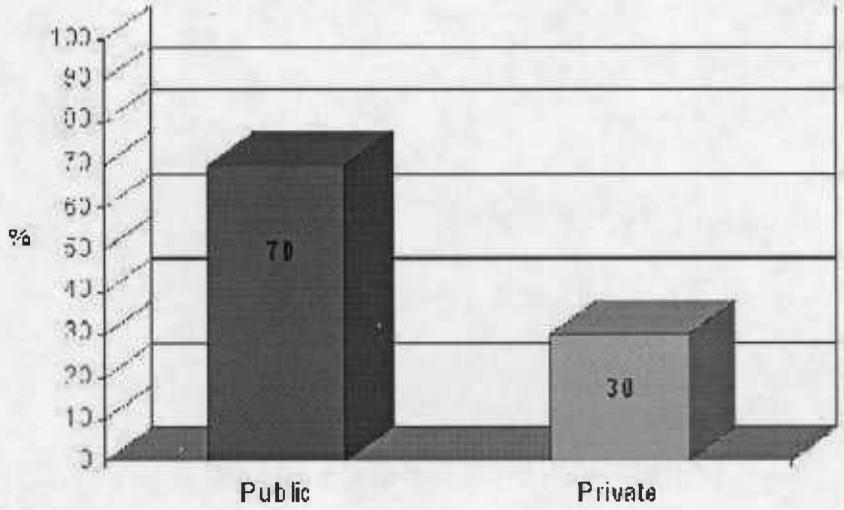
*Baltimore City accounts for 19% of the region's need for alcohol and drug treatment

Figure 2: Proportion of Individuals Receiving Alcohol and Drug Treatment Among Those Who Need Treatment in Maryland as Compared to the Nation



[1]Substance Abuse and Mental Health Services Administration (SAMHSA) National Household Survey on Drug Abuse, 1999

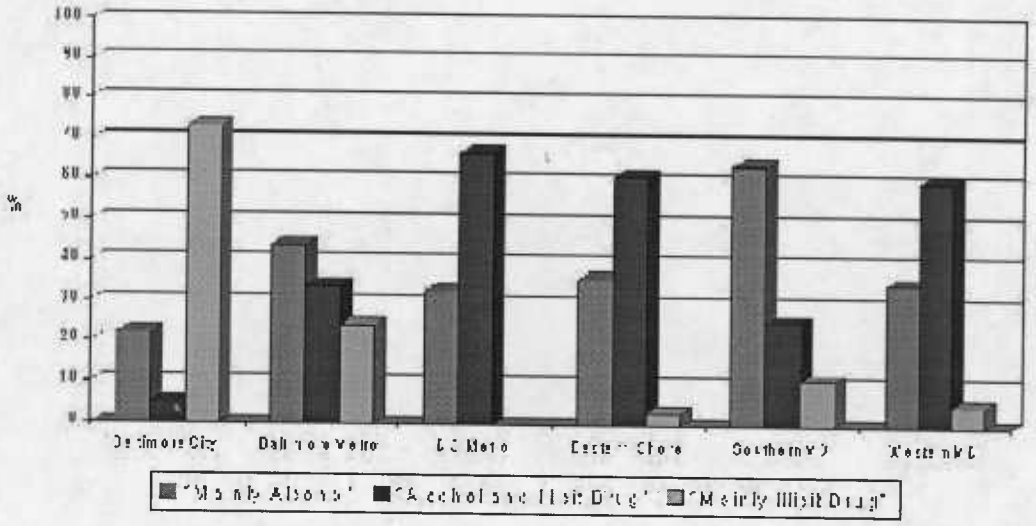
Figure 3: Percent of Individuals Accessing Publicly vs Privately-Funded Alcohol and Drug Treatment in Maryland[1], FY 1999



[1] Includes both adults and adolescents receiving treatment in an DHMH-certified program.

Each region of the State also has its own profile of addiction (See Figure 4). These profiles demonstrate regional differences in drugs of choice and varying patterns of poly- drug use (including alcohol). As the State learns more about these patterns of drug and alcohol abuse, it can expand and improve the treatment system so that it provides the most appropriate and effective treatment. (A statewide inventory of all Maryland certified drug and alcohol treatment programs and county specific maps of treatment program locations are included in Appendix E.)

Figure 4: Regional Breakdown of Types of Alcohol and Drug Problems among Individuals in Treatment in 1997



The estimated nationwide economic cost to society from alcohol and drug abuse is **$246 billion**[6]. This total includes:

- **$176 billion** in lost earnings on account of lost productivity related to premature death, incarceration, and impaired productivity.
- **$40 billion** related to other effects on society, including crime, social welfare administration, motor vehicle crashes, and fire destruction.

The estimated nationwide economic cost to society from alcohol and drug abuse is $246 billion[6].

- **$29 billion** in medical expenditures related to drug and alcohol abuse and addiction. (This estimate included the costs related to drug and alcohol treatment, prevention, and research, and the costs associated with the medical consequences of addiction, such as

HIV and Hepatitis C infections.)

Local experts have estimated that addiction and its consequences cost Maryland approximately ***$5.5 billion each year***[7]. Expanded access to drug treatment services will help reduce these costs and save lives.

The cost-effectiveness of drug and alcohol treatment has been demonstrated repeatedly by both national and local studies of treatment effectiveness. The National Treatment Improvement Evaluation Study (NTIES) found that alcohol and drug treatment's average economic benefit to society was **3 times greater** than the average cost of one treatment episode[8]. Other studies also demonstrate the significant economic benefits of drug and alcohol treatment:

- A study of California's drug treatment system demonstrated that **every $1 invested in drug and alcohol treatment saved taxpayers $7 in future costs**[9].

Local experts have estimated that addiction and its consequences cost Maryland approximately $5.5 billion each year[7].

- The California Study also found that **treatment generally paid for itself starting the first day that it was delivered**, through savings derived primarily from reduced crime and criminal justice system costs.[10]

- The National Treatment Improvement Evaluation Study (NTIES) found that in the year after treatment **health care costs decreased by 11%**[11].

Several Maryland treatment program studies and national studies including Maryland programs demonstrate that drug treatment has alleviated problems associated with addiction. Drug and alcohol treatment has:

- ***Reduced overall drug use***:
  - **78%** reduction in drug use among aftercare clients discharged from treatment. (Allegany County, Massie Unit, 1998.)
  - **60.6%** reduction in drug use after treatment. (Carroll County, residential treatment program, 2000.)
  - **77%** reduction in heroin use six months after treatment. (Ball/Ross, Study of Baltimore methadone programs, 1991.)
- ***Increased employment***:
  - **81%** of clients who experienced work-related problems successfully obtained employment or resolved occupational problems after treatment. (Allegany County, Massie Unit, Residential ICF, 1998.)

- **79%** full or part-time employment rate after discharge from outpatient treatment. (Calvert County, 1998.)

- ***Reduced welfare dependence***:

  - **11%** decrease in welfare dependence among 4,400 individuals one year after treatment. (National Treatment Improvement Evaluation Study, 1997.)

- ***Reduced child welfare system involvement***:

  - **50%** reduction in child welfare system involvement after completion of treatment. (United States General Accounting Office, 1998.)

- ***Reduced criminal activity***:

  - **50%** reduction in arrests (excluding technical violations) in Correctional Options Program (COP) participants in Maryland. (COP involved drug testing, graduated sanctions, and/or drug treatment.) (Recidivism Status Report on the Correctional Options Program, 1997.)

  - **64%** reduction in arrests for any charge and **78%** reduction in drug sale crimes among 4,400 individuals one year after treatment. (National Treatment Improvement Evaluation Study, 1997.)

In February 2000, the Drug Treatment Task Force conducted a needs assessment to evaluate the state of Maryland's drug treatment system. Task Force staff convened three focus groups and conducted several interviews with treatment community advocates and leaders. Two groups consisted of County Addictions Treatment Coordinators and/or Health Officers for the eastern and western counties, and the third group consisted of a cross-section of alcohol and drug treatment providers. Each group discussed the following topics:

- On what types of services and infrastructure would you spend additional drug treatment funds?

- What barriers exist to providing effective treatment services in your region of the state?

In addition to attending the focus groups, each county presented the Task Force with documentation of pressing unmet treatment needs in their communities that they would propose meeting with additional funds.

The needs assessment found that many publicly funded treatment programs across Maryland are filled to capacity. (See Table 1 for a description of these services.) All counties report significant treatment gaps within their geographical area. Because of this shortfall, clients seeking treatment, especially those who are uninsured or underinsured, are unable to access the full range of services necessary for recovery. Several thousand individuals are turned away from treatment programs every month. Many of the individuals who are turned away are indigent, uninsured, or underinsured.

Key themes that emerged from this needs assessment process included:

- **Several modalities of treatment are scarce or almost totally unavailable in some parts of Maryland.** These modalities include:

  - Detoxification services
  - Residential treatment services
  - Halfway housing

Table 1:
PRIMARY MODALITIES OF TREATMENT FUNDED BY THE MARYLAND ALCOHOL AND DRUG ABUSE ADMINISTRATION

Detoxification Services – Detoxification is a process of withdrawing a person from a specific psychoactive substance in a safe and effective manner. The goal is to medically stabilize a person so that he may actively participate in treatment without suffering from the effects of alcohol or drug withdrawal. Detoxification serves as an adjunct to treatment and is not considered to be treatment by itself. Detoxification can occur in any modality of treatment.

Intermediate Care Facility (ICF) - a residential treatment facility for alcohol and drug clients who do not require hospitalization. Program provides an intensive drug treatment regimen of individual and group therapy as well as other activities aimed at the physical, psychological, and social recovery of the addicted individual. Clients usually remain in residence for 2-6 weeks.

Medication-Free Residential - includes the therapeutic community (a long term psychosocial program which focuses on behavior change through a highly regimented, encounter group therapeutic approach), as well as adolescent group homes.

Intensive Outpatient - a non-residential program which provides highly structured treatment services to clients and their families using a "step down" model of intensity ranging from 25 hours to a minimum of six hours a week.

Outpatient - a non-residential program that provides diagnosis, treatment and rehabilitation for alcohol and/or drug abusers. The client's physical and emotional status should allow him/her to function with support in his/her usual home/work environments.

Medication Assisted - a non-residential program offering drug abuse treatment and rehabilitation employing methadone in the detoxification or maintenance treatment of opiate and narcotic drug abusers as one part of the treatment regimen.

Correctional Services - alcohol and drug abuse assessment, treatment and rehabilitation services delivered within a State or local correctional facility.

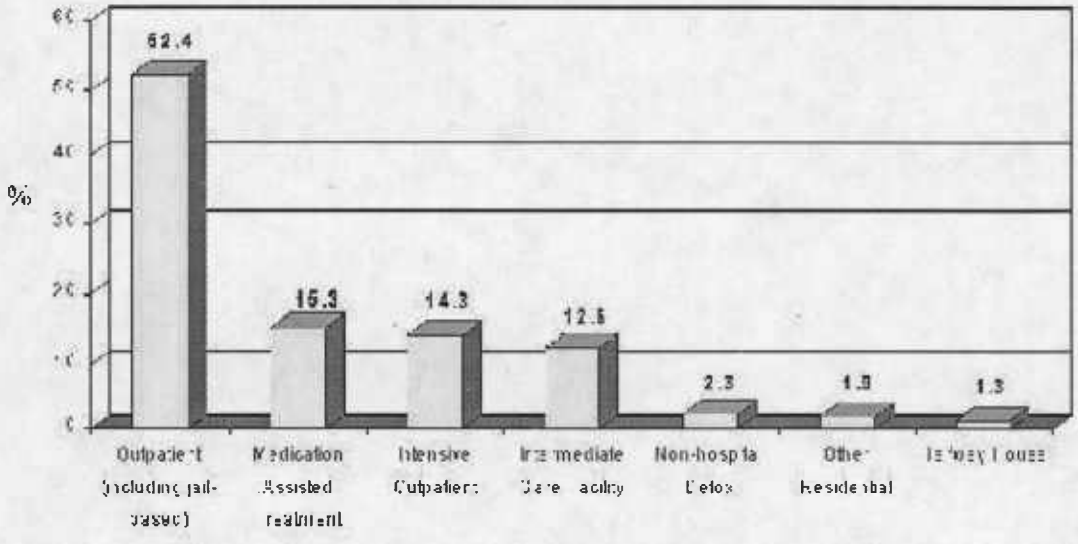
Halfway House - a transitional residential care facility providing time-limited services to clients who have received prior evaluation or treatment in a primary or intermediate care program. Clients are expected to seek employment and move to a position of personal and economic self-sufficiency.

The needs assessment findings were confirmed by FY 99 Substance Abuse Management Information System (SAMIS) data calculated by the Center for Substance Abuse Research. The data indicated that:

- **82%** of the services received in Maryland were outpatient or intensive outpatient services (including medication assisted and jail-based treatment)
- **2.3%** of the services received were non-hospital detoxification
- **14.5%** of the services received were in residential settings (including treatment received in intermediate care facilities)
- **1.3%** of the services received were in halfway houses.

...clients may only receive one or two types of care that they need, or they may be placed in less intensive treatment as opposed to the appropriate level of care because of the severe shortage of intensive or residential services.

Figure 5: Types of Alcohol and Drug Treatment Services Received in Maryland[1], FY 1999



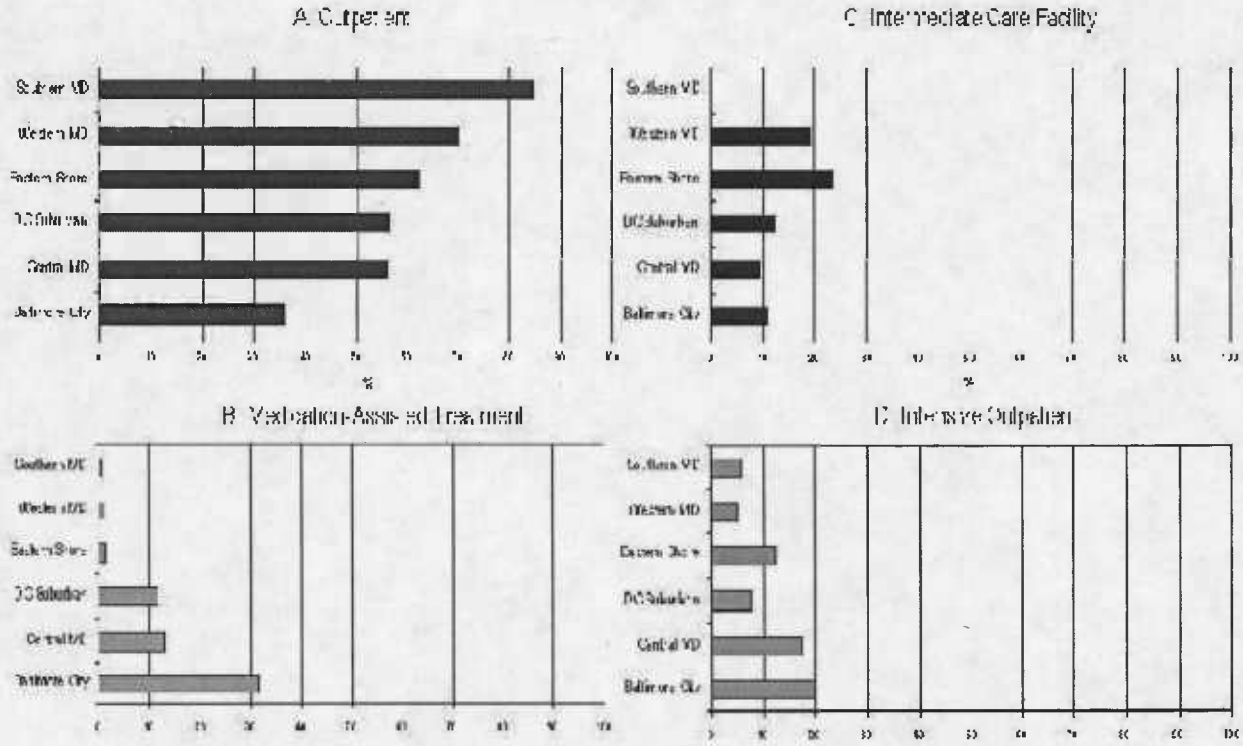
[1] Important Note: The percentages reported here reflect services that were actually delivered based on the services that were available. For example, if more intensive outpatient programs existed, the proportion of clients accessing these services most likely would increase.

The percentages reported in Figure 5 reflect the services that were actually delivered based on the types of services that were available. Due to the lack of services in certain areas of the continuum of care, it is difficult to move clients through all required and appropriate levels of treatment. Therefore, clients may only receive one or two types of care that they need, or they may be placed in less intensive treatment as opposed to the appropriate level of care because of the severe shortage of intensive or residential services.

The lack of halfway houses is particularly problematic since individuals who have completed treatment frequently return home to unhealthy environments where other persons are abusing drugs or alcohol. Exposure to such an environment early after treatment can trigger relapse and other difficulties. Establishing increased access to transitional housing after treatment would improve the success of treatment that is presently offered.

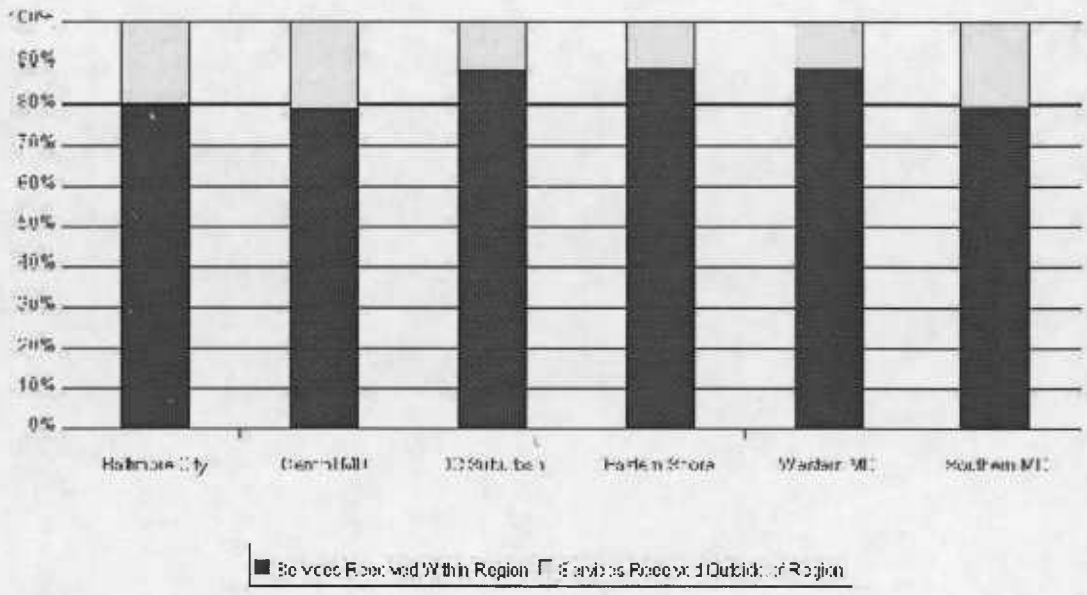
FY 99 SAMIS data also demonstrated that the types of drug and alcohol treatment services that are available vary widely by region (Figure 6) and that 80-90% of individuals receive services within their region of residence (Figure 7).

Figure 6: Types of Alcohol and Drug Treatment Services Received by Region, FY 1999



[1] Interpretation Note: The percentages reported here reflect services that were actually delivered based on the services that were available. For example, if more intensive outpatient programs existed, the proportion of clients receiving these services most likely would increase.

Figure 7: Alcohol and Drug Treatment Services Received Within and Outside of Client Region of Residence, FY 1999



The needs assessment also found that:

- **Treatment infrastructure issues are critical to address with additional funding.**

  - Drug and alcohol treatment system salaries are too low, impeding the effective delivery of drug and alcohol treatment services.

    Treatment system staff salaries are extremely low, ranging from $17,950 for a Counselor Trainee to $25,921 for a senior Counselor III position[12].

    Treatment system staff salaries are extremely low, ranging from $17,950 for a Counselor Trainee to $25,921 for a senior Counselor III position[12]. These low treatment system salaries make it difficult to employ and retain well-trained individuals. Without experienced staff, providers have a hard time delivering effective treatment.

    As of August, 2000, the average job vacancy rate within the treatment system was 21%[13]. Unless the overall salary scale is increased, this problem will worsen as treatment services are expanded and licensure requirements escalate.

- Program performance measurement will improve the management and effectiveness of drug and alcohol treatment programs.

  Programs are eager to receive fair performance evaluations because these evaluations enable programs to assess effectiveness and make specific changes and improvements based on information and data.

III. DISCUSSION OF RECOMMENDATIONS

AVAILABILITY COMMITTEE RECOMMENDATIONS

Drug and Alcohol Treatment Financing

To expand access to drug and alcohol treatment services and to improve the effectiveness of the treatment system, Maryland needs to significantly increase funding for drug and alcohol treatment.

Presently, Maryland spends approximately $123 million in State and federal funds for drug and alcohol treatment services.[14,15] There are three primary funding sources for drug and alcohol treatment:

- Grant funds (both state and federal)
- Private insurance
- Medicaid (public insurance for low income individuals)

...directing additional and sustained funding for treatment will help Maryland achieve its goal of providing adequate and appropriate drug treatment for all citizens.

Additional treatment system funding should come from both public and private sources. This year's $25 million treatment funding increase, and the FY 2002 $22.2 million funding increase in the Governor's budget are significant first steps toward closing the treatment gap, especially since funding is being targeted to areas of greatest need. However, directing additional and sustained funding for treatment will help Maryland achieve its goal of providing adequate and appropriate drug treatment for all citizens

This year's $25 million treatment funding increase, and the FY 2002 $22.2 million funding increase in the Governor's budget are significant first steps toward closing the treatment gap, especially since funding is being targeted to areas of greatest need.

■ **To achieve sufficient funding for a comprehensive drug treatment system, the Task Force recommends:**

A. Increasing baseline drug and alcohol treatment system funding by at least an additional $300 million over the next ten years.

Increasing access to drug treatment programs is essential because it will decrease the serious and negative consequences of addiction that cost society money, and more importantly, lives. Experts estimate that addiction costs Maryland $5.5 billion per year with lost productivity, criminal justice, welfare, child welfare and health care costs contributing to this total. More disturbingly, last year's drug overdose death rate in Baltimore City averaged approximately one per day, surpassing the City's homicide rate.

As the national and local studies cited in this report demonstrate, with increased access to treatment, individuals will be less likely to commit crime, contract chronic and life threatening diseases (such as HIV and Hepatitis C), and will be more likely to work, pay taxes and care for their families. These benefits will reduce State spending on several public systems, including criminal justice, welfare, child welfare and health care. These savings will significantly outweigh the costs of increasing baseline drug and alcohol treatment system funding by $300 million[16].

To calculate the $300 million estimate, the Task Force worked with the Alcohol and Drug Abuse Administration and Center for Substance Abuse Research at the University of Maryland. The group used a mathematical model (See Appendix F) that extrapolates the cost of treating all individuals who need drug and alcohol treatment in Maryland with the limited continuum of care presently available. This calculation assumes that:

- It is difficult to identify and require the treatment of every addict.
- The present continuum of care needs to be significantly enhanced and expanded to include sufficient quantities of each treatment modality and treatment services enhancements, such as housing and medical services, as appropriate.

The $300 million additional baseline funding estimate also assumes the availability of both public and private funding sources. Funding increases should include allocations for drug and alcohol treatment program operations and capital expansion. The Drug Treatment Task Force has begun work on a second statewide needs assessment that will ask Maryland's twenty-four jurisdictions to estimate their specific operational and capital needs. These estimates will help inform the State's investment of additional operational and capital funds.

While the recommendation is that at least an additional $300 million should be added to the baseline funding for the treatment system over the next ten years, this recommendation does not translate into an automatic $30 million/year funding increase. Each year the State, the proposed Drug

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and Alcohol Council (See page 31 for Council description), and treatment system stakeholders should evaluate what level of investment would be appropriate. This yearly estimate would be helpful because the out-year costs of treatment are difficult to predict.

Presently, new treatments and medications are under development and the treatment field may see improvements in the treatment options available similar to the advancements achieved in the treatment of mental illness over the last decade. These advancements, if achieved, will affect the cost of treatment in an unpredictable manner. Yearly evaluations are the most effective way of measuring the appropriate level of treatment system investment. Additionally, as the treatment system expands, it will be important to measure how many and the types of clients who are newly accessing services. This measurement will help the State and its localities gauge the education and outreach efforts that will be necessary to draw more individuals into treatment.

In addition to calculating the additional funding that would be required to expand the drug and alcohol treatment system, the Drug Treatment Task Force also researched funding mechanisms in other states, including Pennsylvania, Massachusetts and Arizona. The Task Force selected these states because they each claim some level of success in expanding access to treatment with funding mechanisms that differ from Maryland's.

In Massachusetts, the Task Force learned about the behavioral health carve out that Massachusetts uses to manage its mental health and drug treatment services funded by Medicaid. The Medicaid Drug Treatment Workgroup will consider this model, along with other models, as the Workgroup designs a potential drug and alcohol treatment carve out from the HealthChoice program.

In Arizona, the Task Force investigated the idea of regional funding of drug treatment as opposed to funding treatment through twenty-four county government structures, which Maryland does now. While this practice has produced positive results in some areas of Arizona, such as Tucson, Task Force members expressed concern about moving to a regional model in FY 2002 without more research and evaluation on how much this change would cost the State and whether these costs would be outweighed by savings to the treatment system.

The proposed Alcohol and Drug Council should continue to research how different funding mechanisms may increase treatment availability. While grant funding is essential because it supports access to community-based treatment services, adding more fee-for-services options or experimenting with other funding mechanisms may generate better access to treatment with the funding that the State currently invests. Investigating this possibility is critical and should remain a priority.

To facilitate the responsible expenditure of additional funds for treatment during FY 2002, the Task Force recommends implementing important system reforms that will improve coordination of and accountability for the public funds presently spent to support drug treatment. Suggested system reforms include improving the process for distributing drug treatment grant funding. This change would involve:

- Holding individual counties harmless by providing them with FY 2001 level grant funding and their portion of the $18.5 million allocated from the Cigarette Restitution Fund in FY 2001.

- Allocating new FY 2002 services funding both to individual counties and regions to support expansion of expensive and/or capital intensive treatment services identified through a needs assessment process. The process for distribution and expenditure of these funds would include:

  - ADAA and Drug and Alcohol Council representatives would distribute a request for proposals, review the requests, and approve final funding proposals.

  - Neighboring counties that receive individual distributions (such as Baltimore City and Baltimore County) would meet to discuss sharing resources to expand services in common need areas and would consult stakeholders from their region about these issues.

  - Counties sharing in regional allocations would meet to determine the use of regional funds and would consult stakeholders when planning for the expansion of the regional continuum of care.

  - The Alcohol and Drug Abuse Administration and the Drug and Alcohol Council should develop a formula to guide "regional" funding distributions.

    The State also could use new FY 2002 services funds to support and expand services traditionally funded by the State, such as residential and intensive outpatient treatment for women, women with children, and adolescents.

- Inviting counties and regions to apply for additional services funding through the Substance Abuse Treatment Outcomes Partnership (S.T.O.P.) program. The statute creating this program requires the Department of Health and Mental Hygiene to work with the Task Force on the competitive distribution of these funds. Counties are able to apply for State funds to match local funds dedicated to supporting drug and alcohol treatment for underserved populations. These competitive grants will generate commitment to funding alcohol and drug treatment at the local level and encourage counties to improve treatment access for presently underserved populations.

B. Pursuing meaningful implementation of parity for drug and alcohol treatment services covered by private health insurance.

While the Task Force has focused almost all of its time reviewing the publicly funded treatment system, it is important to note that there is significant work left to be done on the role of the private treatment system and the importance of private insurance as a payer of these services.

The proposed Drug and Alcohol Council shall make one of its priorities investigating the coverage of drug and alcohol treatment since the implementation of insurance parity for these services a couple of years ago. Has insurance coverage for these services increased as a result of this significant change in law and policy? Or, has insurance for these services actually decreased because insurance policies do not cover these services now in order to avoid drug and alcohol treatment parity requirements? The Drug and Alcohol Council and

other relevant stakeholders, including insurers and employers, should work together to answer these questions and recommend any necessary changes that would improve the ability of insured citizens to use their private health coverage when seeking drug and alcohol treatment.

C. Implementing recommendations made by the Medicaid Drug Treatment Work Group to improve the delivery of drug treatment services to Medicaid recipients.

During the past couple of years, providers and consumers have alerted officials about the difficulty in obtaining timely authorization of appropriate drug and alcohol treatment services and the lost income due to the reduction in services since the implementation of HealthChoice (Maryland's Medicaid managed care program). As a part of its work on drug and alcohol treatment financing, the Task Force requested that the Department of Health and Mental Hygiene present data describing the number of drug and alcohol treatment services delivered to HealthChoice participants, as compared to the number of these services delivered under Medicaid before the implementation of the HealthChoice program.

The Department of Health and Mental Hygiene's HealthChoice encounter data[17] indicated that:

- The volume of drug and alcohol treatment services delivered decreased after the implementation of HealthChoice. Overall, there was a **70% drop** in the units of service from FY 96 to FY 99.

- Of those individuals who received treatment, the average number of units of services they received fell **by 64%** from FY 96 to FY 99.

In response to the data and anecdotal evidence, and upon the request of the Maryland Drug Treatment Task Force, the Department of Health and Mental Hygiene and HealthChoice Managed Care Organizations worked to document further the delivery of drug treatment services under the HealthChoice program. In addition, a Medicaid Drug Treatment Workgroup was formed to make recommendations on how to improve the delivery of services.

The Medicaid Drug Treatment Workgroup agrees that substantial improvements are needed to ensure that HealthChoice enrollees receive appropriate and timely drug and alcohol treatment services.

The Medicaid Drug Treatment Workgroup agrees that substantial improvements are needed to ensure that HealthChoice enrollees receive appropriate and timely drug and alcohol treatment services. Based on the work of the Workgroup, the Department of Health and Mental Hygiene is pursuing two changes to improve access to and appropriate delivery of drug and alcohol treatment services to HealthChoice recipients. The two changes include:

- Immediately implementing the Substance Abuse Improvement Initiative suggested by the Managed Care Organizations and agreed to by the Medicaid Drug Treatment Workgroup. Changes highlighted in this agreement include implementation of a self-referral option for patients, improved treatment pre-authorization and reauthorization guidelines, guaranteed payment to non-network providers who treat Medicaid patients, timely payments to all providers, and increased opportunities for community-based drug treatment providers to become network providers.

  These changes should make it easier for HealthChoice enrollees to access appropriate, community-based drug and alcohol treatment. Clients will be able to go to local treatment programs and request treatment, regardless of whether the treatment provider has a contract with a HealthChoice Managed Care Organization. HealthChoice Managed Care Organizations will pay the provider for the treatment as long as the provider is a Maryland certified drug and alcohol treatment program. This new process provides a "no-wrong-door" approach for clients seeking treatment and encourages alcohol and drug treatment providers to accept HealthChoice clients because payment is guaranteed.

- Designing a carve out of drug and alcohol treatment services from the HealthChoice program with the intention of implementing it as the default option unless the changes above, based on evaluation criteria developed by the Medicaid Drug Treatment Workgroup, are found to support the appropriate delivery of drug treatment services.

Based on the data presented by the Department of Health and Mental Hygiene and the HealthChoice Managed Care Organizations and the expert presentations made to the Medicaid Drug Treatment Workgroup, carving out drug treatment services is a viable option for improving the delivery of drug treatment services to Medicaid recipients. From January through June 2001, DHMH will work with the Medicaid Drug Treatment Workgroup to design the carve out of drug treatment services from the HealthChoice program.

Before implementing a carve out, the success of the first six months of the HealthChoice Substance Abuse Improvement Initiative will be evaluated. At the end of the evaluation period (mid-November 2001), the Medicaid Drug Treatment Workgroup will reconvene to recommend to the Department of Health and Mental Hygiene and the Administration whether to remain with the newly implemented HealthChoice improvements or immediately begin implementing a carve out of drug treatment services from HealthChoice, with full implementation expected no earlier than January 2003.

The Task Force recommends an open, community-based process to support the execution of these important changes, both to facilitate public comment and to draw upon the significant expertise of the Maryland drug and alcohol treatment field. The Task Force suggests that the Department of Health and Mental Hygiene invite members of the treatment community and Task Force to participate in designing and implementing all of these important policy and programmatic changes.

Meeting the Treatment Needs of Special Populations

In addition to drafting three of the Task Force's formal recommendations, the Availability Committee also worked on access to care issues related to special populations. The Committee met with representatives from the Alcohol and Drug Abuse Administration and the Department of Human Resources to review drug and alcohol treatment policies that affect families receiving Temporary Cash Assistance (welfare), families having contact with the child welfare system, and pregnant and postpartum women. The Committee also met with the Maryland Hospital Association and some of its members to discuss a proposed emergency room pilot program that would increase timely access to care for addicted individuals presenting at the emergency room. Task Force staff also completed an inventory of drug treatment programs and funding for criminal justice involved individuals. This inventory, the first of its kind, will help State agencies and local jurisdictions review and refine drug treatment system investments affecting this important population.

The State and local jurisdictions are supporting innovative programs for these special populations; however, more work and financial support are needed to expand and improve the services that are presently available. Additionally, the Task Force did not have time to consider the needs of every special population. Further investigation should be completed by the proposed Drug and Alcohol Council, in cooperation with appropriate State agencies, on the needs of other special populations, including adolescents, adolescents involved in the juvenile justice system, individuals with co-occurring addiction and mental illness, individuals with somatic illnesses exacerbated or caused by their addiction, including individuals infected with HIV and Hepatitis C, and individuals who are both addicted and physically or mentally challenged.

Specific populations and programs that the Task Force did address in its work include:

- **Women Receiving Temporary Cash Assistance (Welfare)**

Task Force members met with Alcohol and Drug Abuse Administration and Department of Human Resources staff to review policies relating to women and other heads of families receiving welfare benefits who need treatment. Issues addressed included:

- How welfare offices are identifying and referring individuals to treatment.
- What funds are available to help pay for treatment.

The Task Force supports statewide application of policies initiated by the Department of Human Resources to increase the identification and treatment of women and other individuals receiving Temporary Cash Assistance who have drug and alcohol problems. However, as more individuals, especially women with children, are identified as needing treatment it will be imperative to expand access to treatment that is specifically tailored to these families who are the primary recipients of Temporary Cash Assistance. The type of treatment required usually involves service enhancements, including childcare, transportation, housing and health care for the whole family. Gender specific treatment also has been proven to be extremely effective with these families and Maryland's treatment capacity in this area is limited.

The Task Force recommends that the Drug and Alcohol Council, as one of its first priorities, work with DHR and DHMH to measure the present treatment capacity for this population and the HB 7/SB 671 child welfare system population (see below). As a result of this process, DHR and DHMH, through its Alcohol and Drug Abuse Administration, should create a master plan that outlines:

- The operational and capital funding needed to expand treatment programs that have demonstrated effectiveness in serving these families.

- The estimated number of additional programs that need to be sited to meet this estimated need and suggested geographic locations for these programs based on the location of the population that needs to be served.

- **Families Having Contact with the Child Welfare System**

Members of the Drug Treatment Task Force participated in the HB 7/SB 671 Implementation Committee that developed a statewide protocol for integrating child welfare and drug and alcohol treatment services. Parental substance abuse and addiction has become a key factor in escalating reports of child abuse and neglect in Maryland and throughout the United States. A 1997 Child Welfare League of America study conducted in Maryland estimated that 60% of child welfare cases involved parental substance abuse. Currently, in 72% of all out-of-home placements of children in Maryland, parental substance abuse or addiction is a contributing factor. Clearly, expanding drug and alcohol treatment for this population is critical.

Through the HB 7/SB 671 Implementation Committee, recommendations were developed for identifying and referring families having contact with the child welfare system to treatment. A report describing this protocol was submitted to the legislature for its consideration in mid-December, 2000. (Appendix G)

The Availability Committee also reviewed the federal child welfare waiver that Maryland received that will support the provision of immediate and enhanced drug treatment services for families whose children are in foster care. Foster care funds will pay for drug and alcohol treatment services and enhancements for populations served by the federal waiver[18].

Parental substance abuse and addiction has become a key factor in escalating reports of child abuse and neglect in Maryland and throughout the United States. A 1997 Child Welfare League of America study conducted in Maryland estimated that 60% of child welfare cases involved parental substance abuse.

Frequently, the types of treatment services and expansion that will be needed by families receiving Temporary Cash Assistance also will be needed by families having contact with the child welfare system. Families identified by the child welfare system often will require drug

and alcohol treatment with service enhancements, such as child care, medical care, housing and transportation. Gender specific drug and alcohol treatment often will be necessary. Given the increase in demand for gender specific programs that will be incurred by both the Temporary Cash Assistance and child welfare initiatives, the treatment capacity for these populations will need to be expanded if the State hopes to achieve full and effective implementation of both initiatives.

The Task force supports expanding and enhancing services for these families through these joint initiatives led by the Departments of Human Resources and Health and Mental Hygiene. The Task Force recommends that the Drug and Alcohol Council continue to work with the Departments to ensure that policies and programs related to drug and alcohol treatment for these families are consistent with the goals of expanding and improving the effectiveness of the drug and alcohol treatment system statewide. The treatment needs assessment and expansion master plan discussed in the previous section also should incorporate an assessment of the treatment needs and expansion requirements of child welfare involved families.

Given the increase in demand for gender specific programs that will be incurred by both the Temporary Cash Assistance and child welfare initiatives, the treatment capacity for these populations will need to be expanded if the State hopes to achieve full and effective implementation of both initiatives.

- **Postpartum Women**

The Availability Committee and the full Task Force both have met with the Alcohol and Drug Abuse Administration and Department of Human Resources to discuss the implementation of SB 512, which focuses on identifying postpartum women who require drug treatment. During these meetings the Task Force inquired about the outcomes of this initiative and made suggestions about how to improve the delivery of drug treatment services to postpartum women.

The Task Force supports identifying and providing drug and alcohol and treatment to newly parenting women, and recommends further investigation by the Department of Health and Mental Hygiene into how to increase the early identification of pregnant women who require drug and alcohol treatment and how to best deliver services to these individuals.

As more pregnant and postpartum women are identified as needing treatment, appropriate treatment services will need to be expanded. The treatment needs assessment and expansion master plan discussed in the two previous sections also should incorporate an assessment of the treatment needs of and necessary services expansion for pregnant and postpartum women.

- **Addicted Individuals Who Seek Care at the Emergency Department**

Hospitals see the consequences of drug and alcohol abuse firsthand every day, as those addicted to drugs and alcohol, as well as the victims of crimes and vehicular crashes, seek care in hospital emergency departments. According to Drug Abuse Warning Network data for the first six months of 1999, an estimated 152 of every 100,000 residents entered a Baltimore City emergency room for a heroin-related overdose or medical condition[19].

Addicted persons, many of whom are uninsured, place a strain on the resources of hospital emergency departments when using them as a source of primary medical care or treatment for chronic diseases or side effects of drug and alcohol abuse and addiction. When E.D. personnel identify addicted individuals and recommend treatment, there is frequently no treatment immediately available for the patient.

The Maryland Hospital Association has recommended a pilot program (Appendix H) to facilitate immediate placement into treatment of addicted persons presenting at a hospital emergency department. The pilot would entail:

- Placing an addictions counselor in the hospital emergency department during time periods that correspond to peak usage by addicted persons.

- Having the addictions counselor administer an assessment tool that measures addiction severity, medical risk, and treatment readiness on those uninsured individuals identified with an addiction diagnosis.

- Assuring that uninsured patients, identified as appropriate for referral to drug and alcohol treatment services, are contacted the next working day by a case manager who would develop a care coordination treatment plan. This plan would facilitate the delivery of drug and alcohol treatment services and create a linkage with a medical facility for primary medical care.

- Evaluating this model to identify the benefits that could be generated by increased identification and immediate placement into treatment.

The Task Force supports piloting this model, with an evaluation component, at one or two hospitals so that the State and its hospitals can assess the potential benefits and savings that could be gained through widespread implementation.

- **Treatment Available to Individuals Involved in the Criminal Justice System**

Providing drug and alcohol treatment to individuals involved in the criminal justice system is both necessary and prudent because it reduces drug use and crime and creates safer communities. According to a 1998 report, 41% of male and 60% of female arrestees interviewed in Baltimore City needed drug and alcohol treatment[20]. The report estimated that in 1995, approximately 46% of all arrestees in Baltimore City were in need of treatment. The National Treatment Improvement Evaluation Study found a 64% decrease in arrests for any charge and a 78% decrease in drug sale crimes one year after drug and alcohol treatment[21].

Providing treatment for the criminal justice population is also cost-effective. Data from a national study of programs funded by the Center for Substance Abuse Treatment (CSAT) found that drug and alcohol treatment saves taxpayers approximately $9,177 per treated individual. 94% of these savings result from reduced crime-related costs[22]. Additionally, a 1994 RAND report concluded that for every dollar spent on treatment, costs to society associated with crime and lost productivity are reduced by $7.46[23].

Funding for the drug and alcohol treatment of individuals involved in the criminal justice system originates at the federal, state and local level, and flows through multiple State and local agencies, making it difficult to track and coordinate funding and treatment policies. This report marks the first time these figures have been compiled to provide an estimate of how much is spent in total on drug and alcohol treatment for this population.

The criminal and juvenile justice treatment program inventory (Appendix I) demonstrates that Maryland spends a significant amount of funding on drug and alcohol treatment programs serving the criminal justice system population. In FY 2001, the total amount of funding spent on drug treatment for adults and juveniles involved in the criminal justice system was almost $31 million[24]. Several counties, including Baltimore City, allocated new FY 2001 funds for the expansion of treatment programs serving individuals involved in the criminal justice system.

Treatment programs serving this population operate inside institutions of incarceration and within communities. Regardless of where an individual receives treatment initially, whether it be inside an institution or in the community, it is important that services exist to help individuals involved in the criminal justice system continue to access treatment and other support services in the community, such as aftercare and job training, during supervision and after release from custody or supervision. Expanding such treatment and support services should continue to be a priority for the State and local jurisdictions.

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The Importance of Drug and Alcohol Treatment Enhancements

The National Institute on Drug Abuse clearly states that the incorporation of medical, psychological, and social services are "crucial components" of drug treatment programs and the "best" programs are a combination of these various services[25]. Further, research shows that "enhancing treatment services provided to clients is an important means of increasing client retention and improving treatment outcomes."[26]

Despite promising evaluations, enhanced services are not always available to clients. In the State of Maryland, 16 of the 24 local jurisdictions identified at least one specific treatment enhancement that needs to be added to their continuum of care in order to "fill the gap."[27] Unfortunately, even if services are available, clients may not be appropriately "matched" to services[28] or services are severely underused, rendering them ineffective[29]. Therefore, to ensure that drug and alcohol treatment will yield positive results, enhanced services need to be made available, and clients must be appropriately matched to these services.

Employment/Vocational Services

Clients who participated in both vocational services and drug treatment services earned $90/per month more, on average, than clients who completed drug treatment only after a 4 ½ year follow-up period[30]. Clients placed in enhanced treatment service programs in Los Angeles received slightly more employment-related referrals, and experienced a "modest" increase in employment. Clients in comparison programs showed no increase in employment[31].

While increasing the employment and self-sufficiency of drug and alcohol treatment clients remains a major goal, the state of collaboration between workforce development providers and drug and alcohol treatment providers has been difficult on account of few resources to support such collaboration. To help close this gap, over the last two years the State of Maryland has supported an Employment in Recovery pilot program that has provided funding for education and job training programs to individuals receiving alcohol and drug treatment services. While the findings of this program have been promising, the pilot only has operated in three counties: Frederick, Somerset, and Anne Arundel. Investigation as to whether this pilot should be supported statewide should continue.

While increasing the employment and self-sufficiency of drug and alcohol treatment clients remains a major goal, the state of collaboration between workforce development providers and drug and alcohol treatment providers has been difficult on account of few resources to support such collaboration.

Community-based organizations also are concerned about job skills development of drug and alcohol treatment clients. In response to a discussion held by the Task Force's Availability Committee about the importance of integrating workforce development and drug and alcohol treatment services, treatment and workforce development providers in Baltimore City began to meet about these issues and needs. They are in the process of developing specific recommendations that will provide guidance about the types of collaborations, resources and services needed to facilitate movement from addiction to employment through treatment and training. Some preliminary recommendations put forth by this workgroup include:

- Establishing dedicated workforce development program slots for drug and alcohol treatment clients.
- On-site training for workforce development and drug treatment system staff.
- Increased management of multiple requirements faced by clients who are in treatment, employed and possibly involved in the criminal justice system.

Transportation Services

Clients who received transportation services (bus tokens, taxi vouchers, van pool) were less likely to drop out of treatment than a comparison group of clients who needed these services, but did not receive them[32].

Psychological/Family Services

When comparing "treatment as usual" clients to "enhanced treatment group" clients[33], the number of psychosocial services was significantly related to better social adjustment at the six month follow-up among 649 participants in 22 Philadelphia area programs[34]. Basic counseling was associated with increased treatment efficacy among methadone patients in the Philadelphia area. On-site professional services were associated with even greater increases[35]. Receipt of social and family services was positively related to abstinence after treatment[36].

Housing Services

Clients who requested and received housing assistance experienced a 50% improvement of their Addiction Severity Index (ASI) scores concerning drug use, compared to a 25% improvement for clients who requested, but did not receive assistance, and a 41% improvement for clients who reported no housing assistance need[37].

Child Care Services

Clients who requested an received child care assistance had significantly higher program retention rates than those who requested but did not receive child care assistance[38]. Many mothers do not enter alcohol and drug treatment because they do not want to place their children in foster care or lose custody of their children[39]. Alcoholism treatment facilities which provide child care and clinical children's services attract more women into treatment[40].

Stigma is a Barrier to Treatment Expansion

As the State and localities seek new and innovative ways to finance and expand treatment, one issue remains of great concern because it will limit drug treatment system expansion. This issue is Not In My Back Yard Syndrome (NIMBYism). Many localities and communities fight the siting of treatment programs in their communities. Recently, Baltimore County lost a federal case in which the County had prevented the siting of a private drug treatment program in the White Marsh area[41]. Until communities are convinced that reputable and responsible drug treatment programs are an asset to Maryland's communities because they provide urgently needed public health services and jobs, Maryland's drug and alcohol treatment system will expand only marginally.

The Task Force recommends that the proposed Drug and Alcohol Council monitor siting problems in the localities and work with local and state government to ensure that policies promote and not prevent the appropriate expansion of drug and alcohol treatment. The Council also should consider working with other community leaders and programs, including hospitals, to help identify support and potential locations for treatment program expansion.

Until communities are convinced that reputable and responsible drug treatment programs are an asset to Maryland's communities because they provide urgently needed public health services and jobs, Maryland's drug and alcohol treatment system will expand only marginally.

EFFECTIVENESS COMMITTEE RECOMMENDATIONS

A. Treatment System Salaries

- ***Increase salaries for all public drug and alcohol treatment system employees.***

Salaries in the drug and alcohol treatment system are extremely low and noncompetitive with private and other public health and human services fields. Low salaries make it difficult for programs to hire and retain employees who are credentialed, experienced and well-trained. As a result, high turnover makes it difficult for treatment providers to operate at maximum capacity and reduces the effectiveness of the services they deliver. Trained and experienced staff is an essential component of a treatment system that produces the best possible outcomes.

Low salaries make it difficult for programs to hire and retain employees who are credentialed, experienced and well-trained. Trained and experienced staff is an essential component of a treatment system that produces the best possible outcomes.

The Task Force recommends raising salaries for all publicly funded alcohol and drug treatment system employees. Last year, salary increases were included in the $25 million budget increase allocated by the State, and this year the Governor's FY 2002 budget includes the salary increase recommended below.

- The State should implement revised addiction counselor classifications that have been developed by the Department of Health and Mental Hygiene so that position classifications more closely correspond with addiction counselor certification requirements. Moving State treatment system employees into these classifications would result in an average two-grade salary increase.

- Funding to support salary increases for non-State employees also should be allocated to maintain salary parity for publicly funded, private providers who contract with localities to provide drug and alcohol treatment services.

In addition to addressing salary issues, the legislature also should support legislation that would revise the Addiction Counselor certification law by reopening the opportunity for addiction counselors currently working in the field to "grandparent" into the new certification requirement. The new law also would add a "trainee" category to certification, thus enabling new counselors to obtain the experience necessary to meet requirements for certification (Appendix J).

B. Performance Measurement

- ***To improve the effectiveness of the drug and alcohol treatment system and its programs, the Task Force recommends that the State implement a performance measurement system.***

By annually evaluating information from drug and alcohol treatment programs on specific performance indicators the State would be able to improve its management of the drug and alcohol treatment system, resulting in continuous quality improvement for these essential public health services. Lack of understanding and skepticism about treatment effectiveness has been a barrier to treatment expansion. A performance measurement system also would help build public support for additional treatment resources and expansion of these services.

By annually evaluating information from drug and alcohol treatment programs on specific performance indicators the State would be able to improve its management of the drug and alcohol treatment system, resulting in continuous quality improvement for these essential public health services.

A performance measurement system is a management tool that permits the State to measure areas of excellence and identify those programs needing improvement. The system's objective is to improve the overall performance of treatment programs in the State of Maryland so that individuals seeking treatment have the best chance at recovery. Program performance would be evaluated to reflect differences in treatment program approaches and in the client mix across these programs. The performance evaluation would incorporate a dialogue between the State and individual programs to provide a constructive context within which to understand the performance measurement results.

Increased management through performance measurement would strengthen drug treatment program performance and help ensure a prudent use of treatment system resources.

The Task Force has worked very closely with the treatment provider community, state and local program administrators, health care professionals, researchers, business leaders, legislators and others to identify a core set of performance indicators to evaluate treatment program performance. Task Force members learned a great deal from its consultations with these groups. Input from these meetings have informed the Task Force's recommendation in this area so that the resulting system will have community support and practical application.

The system of care in Maryland is diverse, both in terms of program objectives and clientele. It was recognized that any system of measurement that is developed must be sensitive to this diversity. Improving treatment services statewide requires that knowledge of best practices be transferred from those programs that are doing well to those that are not. The State would be able to improve its program and budget management of the drug treatment system through more informed training and technical assistance investments. Increased management through performance measurement would strengthen drug treatment program performance and help ensure a prudent use of treatment system

resources.

Recommended Core Indicators

The Task Force tapped into the national effort to identify a candidate list of performance measures for consideration by State officials and the treatment provider community. The State of Maryland along with other States participated in a national dialogue led by the United States Department of Health and Human Services to identify research-based performance measures. There were many measures identified by this national effort covering drug use, criminal behavior, health status, and environmental factors, such as living arrangements. The challenge for the State of Maryland and the treatment provider community was to identify those measures that were most relevant to Maryland's programs. This is one reason why the Task Force sought the advice and support of Maryland's drug treatment community.

The result of the Task Force's extensive consultation process was a realization that the performance measurement system should be built using a core set of indictors. It also was recognized that there was little need to invent new data collection instruments when existing instruments could meet the requirements of performance measurement. The Task Force's consultation process determined that a modified Alcohol and Drug Abuse Administration Substance Abuse Management Information System (SAMIS) could meet the initiative's needs: SAMIS could be modified to collect the requisite core indicators to satisfy performance measurement requirements.

The core set of performance measures that were ultimately identified reflect expectations of Maryland's drug treatment provider community and relate to national performance measurement efforts. Furthermore, the recommended performance outcome measures are the same as those used in national treatment outcome studies. These linkages give Maryland's drug treatment community the opportunity to connect to national effectiveness efforts. The following constitutes the recommended core set of performance measures:

- ***Current Alcohol and Other Drug Use:*** This would measure drug use changes in terms of current (past 30-day) drug (by type of drug) and alcohol use that is reported to SAMIS in the substance abuse matrix. It would be important to track information describing substances of abuse and their frequency of use at intake and discharge. It would also be necessary to collect this data separately using survey techniques as part of a post-treatment evaluation.

- ***Criminal Involvement:*** This would measure current criminal behavior by asking about the number of times the client was arrested in the past 30 days. This would require slight modification of SAMIS, which already asks about arrests in the past 24 months at intake and past 30 days at discharge. It would be reasonable to keep the current information asked at intake so long as the following question is added: "How many days in the past 30 days were you detained or incarcerated (including being arrested and released on the same day)?"

- ***Employment Status:*** This would measure whether treatment has produced improvement in a client's ability to be self-sufficient by tracking changes in the client's employment status. The current SAMIS definition of employment status could serve as an appropriate measure.

- ***Living Arrangements:*** This would measure changes in a client's environmental status by tracking changes in living arrangements. The objective is to get the addict off the street and

into a stable, safe living arrangement as part of the recovery process. This change of status can be tracked by using the current SAMIS definition of living arrangement.

These outcome measures would apply to adult treatment services and capture the expectations of drug treatment: a reduction in drug use and the damaging consequences of drug use. Performance would be measured at intake, discharge, and after treatment, and outcomes would be tracked for the entire treatment process, not just one treatment episode. Measures of drug use and criminal justice involvement are highly relevant over the entire continuum of care (at intake, discharge, and post treatment); living arrangements or employment measures are more relevant at intake and in a post-treatment evaluation, depending on the type of treatment program.

The system will address the problem of measuring performance when a client remains in treatment for a long duration of time. This possibility is common to methadone and residential programs. A client who remains in treatment for an extended time period is likely to have positive outcomes that go unrecorded because data are not collected until discharge. To remedy this problem, it may be necessary to ask providers to report SAMIS-based progress information periodically during treatment (for example, at 6 and 12 month intervals).

Post-Treatment Performance Evaluation

Evaluations of performance include treatment's long-term effect on drug use and its consequences after an individual is discharged. Numerous national studies costing millions of dollars demonstrate the rationale of providing treatment for drug users. The research reveals that the societal costs of not treating a drug addict far exceed the costs of providing treatment. While these studies have tracked the long-term outcomes of clients who have received treatment, the studies are not program specific. That is, they do not review the effectiveness of treatment by particular treatment modality or program. Additionally, these studies are difficult to complete because it is expensive to locate clients subsequent to discharge.

The Performance Measurement System proposed for Maryland's treatment provider community is intended to be program specific. The State is interested in tracking the performance of individual programs against the specific predetermined outcomes previously described. This presents a serious challenge for tracking post-treatment outcomes. With over 350 individual programs in the State, it would be very difficult to track clients to measure their progress against outcomes once they are discharged from treatment. National studies spent millions of dollars to track a few thousand individuals over a few years to measure changes in their use of drugs, employment status, living arrangements, and so forth for purposes of determining treatment's lasting effect. To perform a similar exercise for each of Maryland's treatment programs would be extremely expensive and methodological problems would exist related to the adequacy of sample sizes across programs, varying degrees of response rates, and tracking individuals over time. While a post-treatment analysis should be done, the question becomes how best to do it.

The Task Force proposes to conduct a post-treatment performance evaluation that would give policy and program managers information on the overall effectiveness of the State's treatment system in reducing drug use and its consequences system-wide. Individual programs cannot be evaluated, but the State can determine, as do national studies, the effectiveness of treatment after discharge. A sample of clients could be drawn and tracked over time to track changes in drug use, employment, criminal behavior, and living arrangements to measure treatment's lasting effect. Performance measurement will lead to treatment program quality improvement, which should

translate into improved post-treatment outcomes as well. The Task Force strongly recommends that a post-treatment longitudinal study be implemented for this purpose. The lead for this task falls naturally to CESAR, which is now engaged in a similar study for the federal Department of Health and Human Services. The Treatment Outcomes Performance Pilot Study (TOPPS II) is examining short- and long-term treatment outcomes by linking to administrative data, such as employment, criminal justice and vital statistics records.

Consultation with the Provider Community

There is strong support for performance measurement within the State of Maryland among those in the treatment provider community. Numerous meetings with treatment providers have revealed a climate of acceptance for the introduction of outcome measures in Maryland's drug and alcohol treatment system. In fact, many members of the treatment provider community view performance measurement as an opportunity to demonstrate their positive results. However, there is concern about the potential risk to their programs. While the Maryland Drug Treatment Task Force has made clear that its intent is to improve treatment's effectiveness, treatment providers nevertheless are skeptical and worry about a hidden agenda to close programs. Therefore, the Task Force worked aggressively to apprise and consult with the stakeholders in Maryland's treatment community to ensure a common understanding, support, and appreciation for performance measurement.

There is strong support for performance measurement within the State of Maryland among those in the treatment provider community.

Meetings were held over the last year and reports were sent to the drug treatment community to solicit their views on how best to implement a performance measurement system. The response was very favorable: providers supported the concept of performance measurement, but raised many important issues, including:

- **General Acceptance of Candidate Measures**: There is strong support for performance measurement among those in the treatment provider community. The treatment community is eager to demonstrate its successful effort to reduce drug use and its consequences in the State of Maryland.

- **Data Reliability Concerns**: Many providers worried about the reliability of data currently reported to SAMIS, especially with respect to the reliability of outcomes measures. The ability to compare performance across treatment programs through reliable data is fundamental to the appropriate implementation of the performance measurement system.

- **Training and Auditing Needs**: Many treatment providers noted that staff training is needed to ensure accuracy and reliability of data reported to SAMIS and that SAMIS monitoring (through auditing) should be intensive to standardize reporting.

- **Interest in Post-Treatment Outcome Effectiveness Information**: Understanding that a longitudinal study would evaluate the treatment system and not specific programs, providers were interested in an ongoing post-treatment study to track drug use, arrest, and employment information.

- **Support for a Neutral Evaluation Body**: An entity such as the Center for Substance Abuse Research (CESAR) was recognized as logical choice for performing analysis of performance mea-

sures, but there is also interest in establishing a scientific and program oversight board to review analysis.

The Task Force recognized the critical importance of these concerns and took steps to address each of them. For example, the Task Force is working with the Maryland Alcohol and Drug Abuse Administration (ADAA) to resolve data reliability issues through enhanced training and auditing capabilities. ADAA has prepared a recommendation to expand its staff and automation capacity to facilitate collection of information, including performance measures.

It is important to recognize that performance measurement is much more than just reporting on indicators. The purpose of the system is to develop an ability to compare performance across groups of treatment providers and not just to report results for any one provider. This in turn requires comparative analysis using sophisticated mathematical models to adjust for "case-mix" differences across programs. The Task Force recommends that the Center for Substance Abuse Research (CESAR), which was established by the Governor's Drug and Alcohol Commission in 1990 as part of the University of Maryland, be used to analyze and disseminate relevant information about performance measurement in Maryland's treatment community.

Implementation Issue

Implementation of the performance measurement system will take time, as it first requires that data concerns be addressed. In the interim, the Task Force recommends pilot implementation of the system. This would involve working with a sample of providers to identify and solve any problems related to the full implementation of the performance measurement system. There are many benefits from a pilot implementation effort, including:

- **Capturing the support** of providers, program managers, and political leaders.
- **Providing feedback to ADAA** about its effort to solve problems related to the reliability and usefulness of performance measures reported to SAMIS.
- **Fostering a climate of trust** within the treatment community about the usefulness of performance measurement as a management tool to increase the quality and efficacy of Maryland's treatment services.
- **Testing data collection protocols** and the information management system that will be developed to produce timely information that is accessible to decision makers and providers of treatment services.

Implementation of the performance measurement system also requires change in how the State collects and maintains data reported to ADAA. The current system is antiquated and non-responsive to the real-time needs of providers and program managers. Only about half of the 354 State certified alcohol and drug treatment providers in Maryland report data electronically to ADAA. For performance measurement to be meaningful, it is critical that data on outcomes be current and not years old because of automation problems. ADAA currently shares computer-processing time on a mainframe, which limits the timeliness of information it receives from the provider community. To address

this problem, ADAA developed a proposal to update its hardware and software systems to enable real-time sharing of data between ADAA and treatment providers. It has identified the University of Maryland's Bureau of Government Research (BGR) to support ADAA's data collection needs. BGR has developed an information management tool known as HATS that is gaining acceptance among treatment providers. It will become the core of the automation solution proposed by ADAA.

Since increasing numbers of agencies are involved in funding and overseeing the delivery of treatment services, an elevated level of statewide coordination would improve the alcohol and drug treatment system's ability to deliver effective services.

C. Governance Structure

- ***To achieve increased coordination, the Drug Treatment Task Force recommends the creation of a Drug and Alcohol Council that would focus on drug and alcohol treatment activities and funding across state agencies.***

Maryland's alcohol and drug treatment system is becoming more sophisticated and complex as it seeks to serve clients involved in a variety of public systems, including health, welfare, child welfare, and the criminal justice system. Since increasing numbers of agencies are involved in funding and overseeing the delivery of treatment services, an elevated level of statewide coordination would improve the alcohol and drug treatment system's ability to deliver effective services. The Drug and Alcohol Council would facilitate the necessary statewide coordination and participation.

Drug and Alcohol Council Charge:

- Planning for the further development and expansion of the alcohol and drug treatment system. Activities related to this charge would include:
  - Reviewing drug and alcohol treatment system budget items within state agency budgets and recommending areas for budget development. All budget recommendations would be provided to the Governor in an advisory capacity.
  - Reviewing state agency policies related to drug and alcohol treatment for consistency and coordination.
  - Working with various stakeholders, including state and local government, consumers, and providers to develop and implement drug and alcohol treatment system initiatives for the expansion and improvement of treatment services.

Composition and Organization

The Drug and Alcohol Council would have a membership of approximately 19 persons, appointed by the Governor with a chairperson appointed by the Governor. The Council should partner with community and treatment provider representatives, such as the Addiction Treatment Advocates of Maryland, to identify community and consumer representation for the Council. Membership categories for the council would include:

- ❑ Secretaries of State agencies involved in providing or purchasing alcohol and drug treatment
- ❑ State program administrators involved in the drug treatment system
- ❑ Local government representatives
- ❑ Service consumer representatives
- ❑ Affected family member representatives
- ❑ Drug and alcohol treatment providers
- ❑ Drug and alcohol treatment advocates
- ❑ Drug and alcohol treatment researchers
- ❑ Legislative branch representatives
- ❑ At large representatives

Drug and Alcohol Council Responsibilities:

- Develop a long-term strategy for improving access to and the effectiveness of drug treatment in Maryland.
- Provide education about the need for effective drug and alcohol treatment in Maryland.
- Ensure the execution of an annual needs assessment of local drug and alcohol treatment service needs. Assessments should address both capital and operational needs of each jurisdiction or region.
- Work with a Scientific Advisory Committee to engage expert advice on treatment system issues, including expansion and effectiveness issues.
- Annually recommend to the Governor an interagency State budget that would achieve the treatment system's needs for the specific fiscal year.
- Submit an annual report to the Governor and General Assembly on the progress of expanding and improving the State's drug treatment systems.
- Collaborate with the Alcohol and Drug Abuse Administration on the allocation of grant funds for drug and alcohol treatment.
- Collaborate with Department of Health and Mental Hygiene on improving the delivery of drug and alcohol treatment services paid for by Medicaid.
- Collaborate with criminal justice agencies on the delivery of drug treatment services for criminal justice system involved individuals.
- Collaborate with welfare and child welfare agencies on the identification of individuals and families needing drug treatment system services and the appropriate delivery of services to these individuals and families.
- Work with Alcohol and Drug Abuse Administration and other appropriate State agencies on the development and implementation of a statewide performance measurement system for drug treatment services.

The official members of the Council would meet on a quarterly basis. The Council also would have a subset of monthly meetings that managers from the various state agency programs would attend and to which appropriate stakeholders would be invited. The Drug and Alcohol Council also should establish a

Scientific Advisory Committee to consult with Maryland on a periodic basis about treatment system issues, including expansion and effectiveness issues. The Task Force recommends creating the Council by Executive Order.

IV. CONCLUSION

Maryland is working aggressively to expand and improve its drug and alcohol treatment system. While immediate expansion and improvements are underway, expanding and rebuilding a chronically underfunded system will take years to effectively accomplish. The Drug Treatment Task Force has created the blueprint for this initiative and has forged the community and State partnerships necessary to realize this vision.

The Task Force is grateful for the support that its work has received from the treatment community and state and local leaders – the process was truly one of consensus building that involved numerous participants who contributed thousands of volunteer hours. Task Force members look forward to the Drug and Alcohol Council working with the Administration, General Assembly and other community leaders to implement the report's recommendations and to expand and improve the effectiveness of these critical, life saving public health services.

ENDNOTES

[1] Individuals who are underinsured have access to health insurance, but the insurance policy may not cover drug and alcohol treatment services adequately or at all.

[2] The total number of individuals in need of drug treatment in Maryland was estimated by the Alcohol and Drug Abuse Administration, in conjunction with the Center for Substance Abuse Research at the University of Maryland. This number is similar to the total calculated by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration in its 1999 National Household Survey on Drug Abuse, which estimated the prevalence of alcohol and drug dependence throughout the United States.

[3] The total number of individuals served by Maryland's drug treatment system was calculated from the Substance Abuse Management Information System (SAMIS) administered by the Alcohol and Drug Abuse Administration. This system collects specific patient information at intake and discharge from every certified drug treatment program in Maryland, including both public and private sector programs.

[4]"Substance Abuse and Mental Health Services Administration National Household Survey on Drug Abuse," 1999.

[5] FY 99 SAMIS data, Maryland Alcohol and Drug Abuse Administration.

[6] Harwood, H., Fountain, Douglas, Livermore, G., "The Economic Costs of Alcohol and Drug Abuse in the United States 1992." U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism, Washington, D.C. 1998. Please note that the estimate of social cost is for 1995.

[7] Estimate done by the Center for Substance Abuse Research, University of Maryland, 1995.

[8] Gerstein, D.R.; Datta, A.R.; Ingels, J.S.; Johnson, R.A.; Rasinski, K.A.; Schildhaus, S; Talley, K.; Jordan, K.; Phillips, D.B.; Anderson, D.W.; Condelli, W.G.; and Collins, J.S. "The National Treatment Evaluation Study: Final Report." Rockville, MD: Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment, 1997.

[9] Gerstein, D.R.; Johnson, R.A.; Harwood, H.J.; Fountain, D.; Suter, N.; and Malloy, K. "Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA)." Sacramento: California Department of Alcohol and Drug Programs, 1994.

[10] Gerstein et al., 1994.

[11] Gerstein et al., 1997.

[12] Treatment system salaries calculated by the Maryland Department of Health and Mental Hygiene's Personnel Department and Alcohol and Drug Abuse Administration.

[13] Average job vacancy rate statistic calculated by the Maryland Alcohol and Drug Abuse Administration.

[14] This estimate includes FY 2001 federal and State funding that supports drug treatment in the public health, criminal justice and Medicaid systems. The Medicaid information used to calculate this estimate was incomplete because it did not include funding for all Medicaid and HealthChoice recipients. (Only Calendar Year 1999 information was available from 6 of the 8 Managed Care Organizations participating in the HealthChoice program.)

[15]The Drug Treatment Task Force was unable to estimate the amount of private health insurance and other private funding that supports drug and alcohol treatment services throughout the State.

[16] For example, the nationally recognized CALDATA study found that every $1 spent on treatment saved taxpayers $7 dollars. Gerstein, et al., 1994.

[17] The Department of Health and Mental Hygiene presented this data with the statement that there were many limitations to the data. The Department enumerated these limitations in a memo provided to the Task Force on July 12, 2000.

[18] Federal foster care funds are not available to pay for drug treatment services for populations who are not served under Maryland's federal waiver.

[19] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. "Mid-Year 1999 Preliminary Data from the Drug Abuse Warning Network." Rockville, Maryland: Drug Abuse Warning Network Series D-14. March, 2000.

[20] Gray, Thomas A. and Wish, Eric D. "Substance Abuse Need for Treatment among Arrestees (SANTA) in Maryland, Technical Report." College Park, MD: Center for Substance Abuse Research, University of Maryland, 1998.

[21] Gerstein et al., 1997

[22] Koenig, Lane; Denmead, G.; Nguyen, R.; Harrison, M.; and Harwood, H. "The Costs and Benefits of Substance Abuse Treatment: Findings from the National Treatment Improvement Evaluation Study (NTIES)." Rockville, MD: Center for Substance Abuse Treatment. 1999.

[23] Rydell, C.P. and Everingham, S.S. "Controlling Cocaine: Supply Versus Demand Programs." Santa Monica, CA: RAND. 1994.

[24] This funding appears in several State agency and local government budgets. Task Force staff is working to separate out criminal justice funding from funding that is already clearly accounted for in the Alcohol and Drug Abuse Administration's budget.

[25] "National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment: A Research-Based Guide." National Institute of Health Publication No. 99-4180. 1999.

[26] Hser, Yih-Ing; Polinsky, M.; Maglione, M.; and Anglin, M.D. "Matching Clients' Needs with Drug Treatment Services." Journal of Substance Abuse Treatment 16:299-305. 1999.

[27] Maryland Drug Treatment Task Force, "Filling in the Gaps: Drug and Alcohol Treatment System Needs Assessment Report." February, 2000.

[28] Hser, Yih-Ing; Polinsky, M.; Maglione, M.; and Anglin, M.D. "Matching Clients' Needs with Drug Treatment Services." Journal of Substance Abuse Treatment 16:299-305. 1999.

[29] Widman, M.; Platt, J.; Lidz, V.; Mathis, D.A.; and Metzger, D.S. "Patterns of Use and Treatment Involvement of Methadone Maintenance Patients." Journal of Substance Abuse Treatment 14:29-35. 1997.

[30] Brown, M.; Longhi, D. and Luchansky, B. "Employment Outcomes of Chemical Dependency Treatment and Additional Vocational Services Publicly Funded by Washington State: A Four-and-a-Half Year Follow-Up Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)." Briefing Paper #4.29. 1995.

[31] Fiorentine, R.; Anglin, M.D.; Greenwood, P.W.; Jacobi Gray, M. "Enhancing Drug Treatment; Evaluation of the Los Angeles Target Cities Project (Years 01-01)." Rockville, MD: Center for Substance Abuse Treatment. 1996.

[32] Fiorentine et al., 1996 and Hser et al., 1999.

[33] The "enhanced treatment group" received additional counseling, medical care, family therapy, and psychiatric services. The "treatment as usual" group received neither these services nor any experimental drug treatment or any nonstandard therapeutic intervention.

[34] McLellan, A. T.; Alterman, A.I.; Metzger, D.S.; Grissom, G.R.; Woody, G.E.; Luborsky, L.; and O'Brien, C.P. "Similarity of Outcome Predictors Across Opiate, Cocaine and Alcohol Treatments: Role of Treatment Services." Journal of Consulting and Clinical Psychology 62:1141-1158. 1994.

[35] McLellan, A. T.; Arndt, I.O.; Metzger, D.S.; Woody, G.E.; O'Brien, C.P. "Effects of Psychosocial Services in Substance Abuse Treatment." JAMA 269:I953-1959. 1993.

[36] Gerstein et al., 1997.

[37] Fiorentine et al. 1996 and Hser et al., 1999.

[38] Fiorentine et al. 1996 and Hser et al., 1999.

[39] Finkelstein, N. "Treatment Issues for Alcohol and Drug-Dependent Pregnant and Parenting Women." Health and Social Work 19:7-15. 1994.

[40] Beckman, L. and Amaro, H. "Personal and Societal Differences Faced by Females and Males Entering Alcohol Treatment." Journal of Studies on Alcohol 47:135-145. In Colby, Suzanne M. and Murrell, W. "Child Welfare and Substance Abuse Services: From Barriers to Collaboration." In Hampton, Robert L., Senatore, V. and Gullotta, T.P., eds. "Substance Abuse, Family Violence and Child Welfare." Thousand Oaks, CA: Sage Publications. 1986.

[41] Smith-Berch, Inc. v. Baltimore County, Md., 68 F.Supp.2d 602 (D.Md. 1999); and 115 F.Supp.2d. 520 (D. Md. 2000).

Appendix A

HOUSE BILL 149

Unofficial Copy 1998 Regular Session
J1 (8lr0609)

ENROLLED BILL

— Environmental Matters/Economic and Environmental Affairs —

Introduced by **Delegates Morhaim and Nathan-Pulliam**

Read and Examined by Proofreaders:

_____
Proofreader.

_____
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____M.

_____
Speaker.

CHAPTER_____

AN ACT concerning

Task Force to Study Increasing the Availability of Substance Abuse Programs

FOR the purpose of establishing a Task Force to Study Increasing the Availability of Substance Abuse Programs; providing for the membership, duties, and staffing of the Task Force; requiring the Task Force to report to certain persons by a certain date; *requiring the Alcohol and Drug Abuse Administration to find a certain location for a certain program;* providing for the effective date ~~and the termination of this Act~~*; providing for the termination of certain provisions of this Act*; and generally relating to the Task Force to Study Increasing the Availability of Substance Abuse Programs.

BY adding to
Article 41 - Governor - Executive and Administrative Departments
Section 18-316
Annotated Code of Maryland
(1997 Replacement Volume and 1997 Supplement)

BY adding to
Article - Health - General
Section 8-901
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

Preamble

WHEREAS, A correlation exists between substance abuse and the commission of crime in the State; and

WHEREAS, In Baltimore City, for example, 50,000 drug addicts are responsible for committing 80% of the crime; and

WHEREAS, Substance abuse programs are effective in treating persons who are addicted to drugs and in reducing crime rates; and

WHEREAS, A drug addict in the State currently must endure a long wait to get into a substance abuse program; and

WHEREAS, Studies show that each $1 invested in a substance abuse program saves the taxpayer $7; and

WHEREAS, A need exists to increase funding for existing substance abuse programs, the availability of the programs for those who need treatment, and the evaluation of existing programs; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article 41 - Governor - Executive and Administrative Departments

18-316.

(A) THERE IS A TASK FORCE TO STUDY INCREASING THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS.

(B) THE TASK FORCE CONSISTS OF THE FOLLOWING MEMBERS:

(1) TWO MEMBERS OF THE HOUSE OF DELEGATES APPOINTED BY THE SPEAKER OF THE HOUSE, ONE OF WHOM SHALL BE THE CHAIRMAN OF THE

HOUSE
SPECIAL COMMITTEE ON DRUG AND ALCOHOL ABUSE OR ANOTHER MEMBER OF
THAT COMMITTEE DESIGNATED BY THE CHAIRMAN;

(2) TWO MEMBERS OF THE SENATE OF MARYLAND APPOINTED BY THE
PRESIDENT OF THE SENATE;

(3) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND
MENTAL HYGIENE;

(4) ONE REPRESENTATIVE FROM THE DEPARTMENT OF HUMAN RESOURCES;

~~(4)~~ (5) THE ATTORNEY GENERAL OR A DESIGNEE OF THE ATTORNEY GENERAL;

~~(5)~~ (6) ONE LICENSED PHYSICIAN WITH EXPERIENCE WORKING IN A SUBSTANCE ABUSE PROGRAM;

~~(6)~~ (7) ONE REGISTERED NURSE WITH EXPERIENCE WORKING IN A SUBSTANCE ABUSE PROGRAM;

~~(7)~~ (8) ONE LICENSED SOCIAL WORKER WITH EXPERIENCE WORKING IN A SUBSTANCE ABUSE PROGRAM;

~~(8)~~ (9) ONE LICENSED PSYCHOLOGIST WITH EXPERIENCE WORKING IN A SUBSTANCE ABUSE PROGRAM;

~~(9)~~ (10) ONE REPRESENTATIVE FROM A COUNTY SUBSTANCE ABUSE PROGRAM;

~~(10)~~ (11) ONE REPRESENTATIVE FROM A CITY SUBSTANCE ABUSE PROGRAM;

(12) ONE REPRESENTATIVE FROM THE MARYLAND ASSOCIATION OF SOCIAL SERVICE DIRECTORS;

~~(11)~~ (13) ONE FORMER ADDICT;

~~(12)~~ (14) ONE POLICE OFFICER;

~~(13)~~ (15) ONE REPRESENTATIVE OF THE DEPARTMENT OF CORRECTIONS;

~~(14)~~ (16) ONE REPRESENTATIVE OF THE DEPARTMENT OF JUVENILE JUSTICE;

(~~15~~) (17) ONE REPRESENTATIVE OF THE OFFICE FOR CHILDREN, YOUTH, AND FAMILIES;

(~~16~~) (18) ONE REPRESENTATIVE OF HOSPITALS IN THE STATE;

(~~17~~) (19) ONE OPERATOR FROM A SUBSTANCE ABUSE PROGRAM; AND

(~~18~~) (20) ONE EXPERIENCED ADDICTIONS COUNSELOR.

(C) THE GOVERNOR SHALL APPOINT THE CHAIRPERSON OF THE TASK FORCE.

(D) THE TASK FORCE SHALL DEVELOP A COMPREHENSIVE STRATEGY FOR INCREASING THE FUNDING AND THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS IN THE STATE BY:

(1) EXAMINING THE SCOPE OF THE PROBLEM OF SUBSTANCE ABUSE IN THE STATE, AND THE NUMBER OF SUBSTANCE ABUSE PROGRAMS THAT EXIST TO ADDRESS THE PROBLEM;

(2) COLLECTING DATA TO DETERMINE THE CORRELATION BETWEEN SUBSTANCE ABUSE AND THE COMMISSION OF CRIMES;

(3) DETERMINING THE EXTENT TO WHICH THE SUBSTANCE ABUSE PROGRAMS ARE ACCESSIBLE TO THOSE ADDICTED TO DRUGS *AND ALCOHOL* WHO SEEK TREATMENT;

(4) DETERMINING THE AMOUNT OF FUNDING CURRENTLY AVAILABLE FOR SUBSTANCE ABUSE PROGRAMS;

(5) TAKING ANY OTHER ACTION NECESSARY AND PROPER TO CARRY OUT THE PURPOSE OF THIS SECTION; ~~AND~~

(6) EXAMINING THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS DESIGNED FOR WOMEN, PREGNANT WOMEN, AND WOMEN WITH CHILDREN, AS WELL AS THE OUTCOMES OF THESE PROGRAMS IN RELATION TO THE LENGTH OF STAY;

(7) EXAMINING THE HEALTH INSURANCE COVERAGE AVAILABLE IN THE STATE FOR SUBSTANCE ABUSE TREATMENT;

~~(6)~~ *(8)* MAKING RECOMMENDATIONS TO INCREASE THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS, BOTH SHORT-TERM AND LONG-TERM;

~~(7)~~ *(9)* EXAMINING THE REASONS FOR PUBLIC OPPOSITION TO SUBSTANCE ABUSE PROGRAMS; AND

~~(8)~~ *(10)* MAKING RECOMMENDATIONS TO DECREASE PUBLIC OPPOSITION TO SUBSTANCE ABUSE PROGRAMS TO ENSURE THAT SUBSTANCE ABUSE

PROGRAMS ARE ACCESSIBLE THROUGHOUT THE STATE TO THOSE ADDICTED TO DRUGS WHO SEEK TREATMENT.

(E) MEMBERS OF THE TASK FORCE SHALL SERVE WITHOUT COMPENSATION EXCEPT THAT THE MEMBERS MAY BE REIMBURSED FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

(F) THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, IN COOPERATION WITH OTHER APPROPRIATE STATE AND LOCAL UNITS, SHALL PROVIDE STAFF SUPPORT FOR THE TASK FORCE TO THE EXTENT POSSIBLE WITHIN EXISTING BUDGETED RESOURCES.

(G) THE TASK FORCE SHALL ISSUE A FINAL REPORT OF ITS FINDINGS, RECOMMENDATIONS, AND COMPREHENSIVE STRATEGY TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY ON OR BEFORE JANUARY 1, 2000.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

8-901.

THE ADMINISTRATION SHALL FIND AN APPROPRIATE BERTH IN AN AREA THAT IS SAFE FOR PUBLIC ACCESS FOR A SUBSTANCE ABUSE PROGRAM KNOWN AS THE U.S.S. SANCTUARY.

SECTION ~~2.~~ *3.* AND BE IT FURTHER ENACTED, That *Section 1 of* this Act shall take effect June 1, 1998. It shall remain effective for a period of 1 year and 6 months and, at the end of January 1, 2000, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect June 1, 1998.

Appendix A

HOUSE BILL 149

Unofficial Copy 1998 Regular Session
J1 (8lr0609)

ENROLLED BILL

—Environmental Matters/Economic and Environmental Affairs—

Introduced by **Delegates Morhaim and Nathan-Pulliam**

Read and Examined by Proofreaders:

_____
Proofreader.

_____
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____M.

_____
Speaker.

CHAPTER_____

AN ACT concerning

Task Force to Study Increasing the Availability of Substance Abuse Programs

FOR the purpose of establishing a Task Force to Study Increasing the Availability of Substance Abuse Programs; providing for the membership, duties, and staffing of the Task Force; requiring the Task Force to report to certain persons by a certain date; *requiring the Alcohol and Drug Abuse Administration to find a certain location for a certain program;* providing for the effective date ~~and the termination of this Act~~; *providing for the termination of certain provisions of this Act*; and generally relating to the Task Force to Study Increasing the Availability of Substance Abuse Programs.

BY adding to
Article 41 - Governor - Executive and Administrative Departments
Section 18-316
Annotated Code of Maryland
(1997 Replacement Volume and 1997 Supplement)

BY adding to
Article - Health - General
Section 8-901
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

Preamble

WHEREAS, A correlation exists between substance abuse and the commission of crime in the State; and

WHEREAS, In Baltimore City, for example, 50,000 drug addicts are responsible for committing 80% of the crime; and

WHEREAS, Substance abuse programs are effective in treating persons who are addicted to drugs and in reducing crime rates; and

WHEREAS, A drug addict in the State currently must endure a long wait to get into a substance abuse program; and

WHEREAS, Studies show that each $1 invested in a substance abuse program saves the taxpayer $7; and

WHEREAS, A need exists to increase funding for existing substance abuse programs, the availability of the programs for those who need treatment, and the evaluation of existing programs; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article 41 - Governor - Executive and Administrative Departments

18-316.

(A) THERE IS A TASK FORCE TO STUDY INCREASING THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS.

(B) THE TASK FORCE CONSISTS OF THE FOLLOWING MEMBERS:

(1) TWO MEMBERS OF THE HOUSE OF DELEGATES APPOINTED BY THE SPEAKER OF THE HOUSE, ONE OF WHOM SHALL BE THE CHAIRMAN OF THE HOUSE SPECIAL COMMITTEE ON DRUG AND ALCOHOL ABUSE OR ANOTHER MEMBER OF THAT COMMITTEE DESIGNATED BY THE CHAIRMAN;

(2) TWO MEMBERS OF THE SENATE OF MARYLAND APPOINTED BY THE PRESIDENT OF THE SENATE;

(3) ONE REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE;

(4) ONE REPRESENTATIVE FROM THE DEPARTMENT OF HUMAN RESOURCES;

~~(4)~~ (5) THE ATTORNEY GENERAL OR A DESIGNEE OF THE ATTORNEY GENERAL;

~~(5)~~ (6) ONE LICENSED PHYSICIAN WITH EXPERIENCE WORKING IN A

~~(11)~~ (13) ONE FORMER ADDICT;

~~(12)~~ (14) ONE POLICE OFFICER;

~~(13)~~ (15) ONE REPRESENTATIVE OF THE DEPARTMENT OF CORRECTIONS;

~~(14)~~ (16) ONE REPRESENTATIVE OF THE DEPARTMENT OF JUVENILE JUSTICE;

~~(15)~~ (17) ONE REPRESENTATIVE OF THE OFFICE FOR CHILDREN, YOUTH, AND FAMILIES;

~~(16)~~ (18) ONE REPRESENTATIVE OF HOSPITALS IN THE STATE;

~~(17)~~ (19) ONE OPERATOR FROM A SUBSTANCE ABUSE PROGRAM; AND

~~(18)~~ (20) ONE EXPERIENCED ADDICTIONS COUNSELOR.

(C) THE GOVERNOR SHALL APPOINT THE CHAIRPERSON OF THE TASK FORCE.

(D) THE TASK FORCE SHALL DEVELOP A COMPREHENSIVE STRATEGY FOR INCREASING THE FUNDING AND THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS IN THE STATE BY:

(1) EXAMINING THE SCOPE OF THE PROBLEM OF SUBSTANCE ABUSE IN THE STATE, AND THE NUMBER OF SUBSTANCE ABUSE PROGRAMS THAT EXIST TO ADDRESS THE PROBLEM;

(2) COLLECTING DATA TO DETERMINE THE CORRELATION BETWEEN SUBSTANCE ABUSE AND THE COMMISSION OF CRIMES;

(3) DETERMINING THE EXTENT TO WHICH THE SUBSTANCE ABUSE PROGRAMS ARE ACCESSIBLE TO THOSE ADDICTED TO DRUGS *AND ALCOHOL* WHO SEEK TREATMENT;

(4) DETERMINING THE AMOUNT OF FUNDING CURRENTLY AVAILABLE FOR SUBSTANCE ABUSE PROGRAMS;

(5) TAKING ANY OTHER ACTION NECESSARY AND PROPER TO CARRY OUT THE PURPOSE OF THIS SECTION; ~~AND~~

(6) EXAMINING THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS DESIGNED FOR WOMEN, PREGNANT WOMEN, AND WOMEN WITH CHILDREN, AS WELL AS THE OUTCOMES OF THESE PROGRAMS IN RELATION TO THE LENGTH OF STAY;

(7) EXAMINING THE HEALTH INSURANCE COVERAGE AVAILABLE IN THE STATE FOR SUBSTANCE ABUSE TREATMENT;

~~(6)~~ *(8)* MAKING RECOMMENDATIONS TO INCREASE THE AVAILABILITY OF SUBSTANCE ABUSE PROGRAMS, BOTH SHORT-TERM AND LONG-TERM;

~~(7)~~ *(9)* EXAMINING THE REASONS FOR PUBLIC OPPOSITION TO SUBSTANCE ABUSE PROGRAMS; AND

~~(8)~~ *(10)* MAKING RECOMMENDATIONS TO DECREASE PUBLIC OPPOSITION TO SUBSTANCE ABUSE PROGRAMS TO ENSURE THAT SUBSTANCE ABUSE PROGRAMS ARE ACCESSIBLE THROUGHOUT THE STATE TO THOSE ADDICTED TO DRUGS WHO SEEK TREATMENT.

(E) MEMBERS OF THE TASK FORCE SHALL SERVE WITHOUT COMPENSATION EXCEPT THAT THE MEMBERS MAY BE REIMBURSED FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

(F) THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, IN COOPERATION WITH OTHER APPROPRIATE STATE AND LOCAL UNITS, SHALL PROVIDE STAFF SUPPORT FOR THE TASK FORCE TO THE EXTENT POSSIBLE WITHIN EXISTING BUDGETED RESOURCES.

(G) THE TASK FORCE SHALL ISSUE A FINAL REPORT OF ITS FINDINGS, RECOMMENDATIONS, AND COMPREHENSIVE STRATEGY TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY ON OR BEFORE JANUARY 1, 2000.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

8-901.

THE ADMINISTRATION SHALL FIND AN APPROPRIATE BERTH IN AN AREA THAT IS SAFE FOR PUBLIC ACCESS FOR A SUBSTANCE ABUSE PROGRAM KNOWN AS THE U.S.S. SANCTUARY.

SECTION ~~2.~~ *3.* AND BE IT FURTHER ENACTED, That *Section 1 of* this Act shall take effect June 1, 1998. It shall remain effective for a period of 1 year and 6 months and, at the end of January 1, 2000, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect June 1, 1998.

Appendix B

Maryland Drug Treatment Task Force:
Availability Committee Participants

Name	Position/Title	Organization
Chair: Dr. Jude Boyer-Patrick, M.D., MPH *	Medical Director	Pathways Drug and Alcohol Treatment Center
Stephen Amos	Executive Director	Governor's Office of Crime Control and Prevention
Diane Banchiere		Advocates for Children and Youth
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Appendix C

Filling in the Gaps:

Statewide Needs Assessment of County Alcohol and Drug Treatment Systems

Drug Treatment Task Force

February, 2001

Overview

Many publicly funded treatment programs across Maryland are filled to capacity and all counties report serious treatment gaps within their geographical area. Because of this shortfall, clients seeking treatment, especially those who are uninsured or underinsured, are unable to access the full range of services necessary for recovery.

Existing research estimates that there are approximately 218,000 to 262,000 persons throughout Maryland in need of alcohol and drug treatment. The Alcohol and Drug Abuse Administration (ADAA) reports that statewide, several thousand individuals are turned away from treatment programs every month. Many of the individuals who are turned away are indigent, uninsured, or underinsured.

When thinking about how to wisely invest tobacco settlement funds earmarked for drug treatment by the Administration, understanding the most pressing and current alcohol and drug treatment needs of Maryland and its different geographical regions is important. To collect information about these pressing needs, Task Force staff conducted a needs assessment to determine regional needs and gaps, as well as barriers to accessing treatment presently offered. Through this process, staff collected information from each county and from a cross-section of alcohol and drug treatment providers.

Based on this information gathered from this needs assessment process, the Task Force recommends spending tobacco settlement funds on three critical activities:

1. Filling in treatment system gaps.
2. Boosting treatment system salaries.
3. Increasing system accountability.

This spending strategy both increases access to and improves the effectiveness of drug treatment services.

The Task Force wishes to thank needs assessment participants for their candor, insight and advice about how to strengthen the alcohol and drug treatment systems in their communities. The Task Force looks forward to working with local jurisdictions to design a comprehensive, statewide continuum of care.

Methodology

Task Force staff convened three focus groups and conducted several interviews. Two groups consisted of the County Addictions Treatment Coordinators and/or Health Officers for the eastern and western counties, and the third group consisted of a cross-section of alcohol and drug treatment providers. Each group met for 2.5 hours and discussed the following topics:

- On what types of services and infrastructure would you spend tobacco settlement funds?

- What barriers exist to providing effective treatment services in your region of the state?

In addition to attending the focus groups, each county presented the Task Force with documentation of pressing unmet treatment needs in their communities that they would propose meeting with tobacco settlement funds.

Key Themes Expressed in Focus Groups and Interviews

Many of the themes described in this report are similar to themes identified in the Drug Treatment Task Force's Interim Report that was released on December 7, 1999. The themes in this report reflect the viewpoints of county Health Officers, Addictions Treatment Coordinators, and a cross-section of alcohol and drug treatment providers.

Key themes expressed in focus groups and interviews include:

- **Several modalities of treatment are unavailable.**

  Several modalities of treatment are scarce and almost totally unavailable in Maryland. These modalities include detoxification services, residential treatment, and halfway house/transitional housing slots. The lack of halfway house placements is particularly problematic since individuals who have completed treatment frequently return home to unhealthy environments where other persons are abusing drugs or alcohol. Exposure to such an environment early after treatment can trigger relapse and other difficulties. Establishing better access to transitional housing after treatment would improve the success of treatment that is presently offered.

- **Treatment infrastructure issues are critical to address with additional funding.**

  - Salaries for treatment counselors, medical staff (such as nurses) and administrative staff (such as billing clerks) are extremely low. This fact makes it difficult to employ and keep well-trained individuals.

  - Jurisdictions should be able to use tobacco settlement funds to support and improve treatment services that are presently offered, since many programs have been running on strained budgets and skeleton staffs.

- **Providers need increased access to training opportunities.**

Both to serve as a source of compensation and to help individuals meet new certification requirements, providers should have increased access to training opportunities. One way of increasing access would be to provide training at community colleges so that training would be more geographically accessible to providers throughout the state.

- **Some programs are running at less than 100% capacity.**

  Some treatment programs are receiving few referrals from managed care organizations and

governmental agencies. This low level of referrals results in these programs having fewer patients and operating at less than 100% capacity.

In addition to the lack of referrals, failure of Managed Care Organizations to authorize treatment causes programs to run at less than 100% capacity. Most programs cannot afford to shoulder the cost of uncompensated care resulting from denied authorizations; therefore programs choose to take fewer patients to control the level of financial loss incurred.

- **Improved and increased services for special populations are needed.**

Several special populations remain underserved, including adolescents, women, women with children, and individuals with co-occurring mental health and substance abuse disorders. Additional services designed to meet the complex needs of these special populations should be developed.

- **Many jurisdictions desire additional or enhanced treatment services for the criminal justice system.**

Some of these services include:

- Continued support for jail-based treatment.
- Support for drug courts and drug-involved offenders.
- Court treatment assessors, who can assess offenders and ensure appropriate treatment referrals.

- **It is difficult to provide treatment under and receive reimbursement from HealthChoice Managed Care Organizations (MCO's) and private managed care organizations.**

  - Obstacles to providing treatment include:

    - Managed care organizations frequently authorize treatment regimens that are shorter than what the American Society of Addiction Medicine (ASAM) assessment criteria recommend. (Publicly-funded drug treatment programs in Maryland receiving Alcohol and Drug Abuse Administration funds or Medicaid funds are required to use ASAM criteria to assess clients.) This is problematic since these managed care authorizations conflict with what is medically recommended.
    - MCO's are requiring increased clinician time to settle disputes about claims. This diverts clinical staff from the treatment of patients.
    - MCO's have not contracted for services with many community-based alcohol and drug treatment providers.
    - Primary care providers do not screen clients for alcohol and drug problems; therefore they miss opportunities to refer individuals to alcohol and drug treatment.

  - Obstacles to receiving reimbursement include:

    - Frequent refusal of MCO's to authorize treatment.
    - Frequent refusal of MCO's to reimburse for appropriate treatment already provided.

- Difficulty ascertaining a client's coverage under HealthChoice because of delays in making coverage data available to treatment providers. (Sometimes coverage data is not available until 90 days after a client is enrolled in HealthChoice. This time frame is sometimes long after a client has left treatment.)

- **"Not in my back yard" (NIMBY) syndrome has made it difficult to site treatment programs and halfway houses, reducing local access to treatment in many communities.**

Many communities and jurisdictions remain uncomfortable with alcohol and drug treatment and resist having treatment programs as members of their community. This resistance has resulted in treatment programs and halfway houses encountering difficulties establishing programs in various communities around the state. As a result, treatment is not readily available in many locations, making it difficult for residents to access care.

Statewide Infrastructure Needs and Priorities

1. **Increased salaries for counselors, medical and fiscal personnel.**

There was unanimous agreement among needs assessment participants that salaries in the alcohol and drug treatment field must be increased and other policy barriers to hiring must be addressed. Presently, salaries in the alcohol and drug treatment field are so low that they are uncompetitive with private and other public health and human services field salaries. The low salaries make it difficult to both hire and keep employees who are credentialed and well-trained.

2. **State personnel policies can impede the hiring of credentialed and skilled staff.**

State personnel policies are frequently out of sync with:

- New laws and regulations for counselor certification.
- The need to serve more complex clients with a full range of personnel, including addictions counselors, nurses and social workers. Hiring categories of personnel other than addictions counselors has proven to be difficult for many jurisdictions because of pay scale differences between addictions counselors and these other professional categories and varying supervisory requirements for different professional categories.

It was strongly suggested that the State review and update clinical and administrative drug treatment position descriptions so that some of these discrepancies can be resolved.

Regional Treatment Needs and Priorities

Eastern Shore

1. **Regional detoxification center.** Presently the only resource for detoxification is the Kent-Sussex Detox Center in Ellendale, Delaware. This center provides only two beds for Maryland residents.

2. **Increased access to medium intensity and long term residential treatment.**

3. **Establishment of a publicly-funded adolescent rehabilitation facility to serve nine Eastern shore counties.**

4. **Creation of halfway house placements for adults and adolescents.**

5. **Comprehensive treatment services for women with children.** These services would include:

   - **Residential treatment programs that incorporate infants and children.** These programs provide drug treatment and as a part of treatment improve parenting skills, employment skills and life skills.

   - **Halfway houses for women with children.** This resource would help to prevent relapse in women who complete a 20–30 day treatment program who need to remain in a drug-free environment to maintain their sobriety immediately after treatment.

   - **Babysitting services for women attending outpatient treatment and self-help recovery groups.**

Western Counties

1. **Halfway houses.** This resource is greatly needed in several Western counties, including Allegany, Garrett, Washington, and Frederick. **Increased halfway house placements in this area would:**

   - **Allow clients to move from treatment to the next appropriate drug-free environment.** Presently, because it is so difficult to secure halfway house placements, treatment providers extend a client's stay in treatment in order to help them remain drug-free until a halfway house placement becomes available. Having better access to halfway house placements would reduce the need for retaining in clients in treatment, and would result in a more cost efficient continuum of care.

   - **Enable individuals to remain in a drug-free environment closer to their communities.** By living in their communities, clients would benefit more from local wrap-around services that help facilitate community re-entry.

<u>County Treatment Needs and Priorities</u>

Allegany County

1. Establishing a new halfway house facility for adults to increase local access to halfway house placements.

2. Establishing transitional counselors in each health department outpatient clinic in Western

Maryland. These counselors would have the primary responsibility of attending to the more intense individual treatment needs of Massie Unit residents discharged to local outpatient treatment clinics.

3. Increasing the amount of staff available and able to treat dually diagnosed adolescents at the Jackson Unit, a residential drug treatment facility for adolescents. During the last six months of 1999, 43% of Jackson Unit clients were diagnosed with a serious mental illness. These patients require comprehensive mental health services in addition to drug treatment.

Anne Arundel County

1. Maintaining present Drug Court capacity and related services.

2. Increasing support for the Offender Treatment Fund, which helps pay for treatment services for criminal justice system offenders. Specific treatment modalities requiring support include:

   - Residential treatment
   - Residential detoxification
   - Intermediate residential care
   - Halfway house services
   - Out-patient treatment

3. Increasing Offender Treatment Fund staff and infrastructure to manage an expanded program.

4. Expanding outpatient treatment services for non-criminal residents.

5. Expanding the Substance Abuse Treatment and Recovery (STAR) program at the county correctional center.

Baltimore City

1. Supporting the current treatment system.

   - Increasing staff salaries to fill vacancies and retain staff.
   - Increasing urinalysis budget to better determine treatment effectiveness.
   - Increasing staff training.

2. Expanding treatment system capacity

   - Increasing access to methadone detoxification and methadone/LAAM maintenance.
   - Increasing access to outpatient detoxification.
   - Increasing access to residential treatment.

3. Improving treatment outcomes through enhancement of treatment services

- Providing case management services that will help link clients with needed ancillary and support services.
- Providing for or facilitate the provision of the following services: mental health treatment, primary health care, vocational/educational, housing, legal representation, and child care.

Baltimore County

1. Establishing an assessment unit in order to provide assessment services, including treatment recommendations and referrals.

2. Expanding inpatient detoxification services.

3. Expanding residential treatment services ranging from intermediate care facilities to longer term therapeutic communities, including facilities serving women with children.

4. Expanding day treatment services.

5. Expanding outpatient treatment services.

6. Expanding methadone maintenance treatment services.

7. Developing halfway house services.

Calvert County

1. Increasing access to halfway house or long-term care placements for the uninsured and those with co-occurring alcohol and drug problems and mental illness.

2. Increasing access to 28-day residential treatment with work release.

3. Establishing a short-term residential treatment facility (20 beds) for adolescents. This program would provide services for adolescents from Calvert, Charles and St. Mary's Counties. Presently, adolescents in Calvert County are sent to Cumberland or Annapolis to receive residential treatment.

4. Increasing access to intensive outpatient services for adolescents and adults. Services would be for 9 hours a week at a minimum. This would type of service would create a treatment option for clients needing more intense services than regular outpatient treatment, but who do not require residential treatment.

5. Increasing access to ambulatory detoxification services.

6. Expanding access to outpatient methadone maintenance services.

7. Increasing resources to facilitate the full implementation of the Break the Cycle program.

This would include support for an additional Addictions Counselor III and urinalysis. Also, support is needed to reduce the ratio of offender to parole and probation agent.

8. Implementing a prevention curriculum for grades K-12 and during the first 3 years of college.

9. Increasing access to psychiatric services for uninsured clients who are dually diagnosed with co-occurring alcohol and drug problems and mental illness.

Caroline County

1. Expanding the adjunctive acupuncture program.

2. Providing comprehensive adolescent intervention and treatment services, including:

- Individual and group counseling at all schools for identified at-risk adolescents and for those assessed as having an alcohol and drug problem.
- Hiring of a trained addiction counselor to participate in all middle and high school Student Assistance Programs.
- Assessment, intervention and treatment for all adolescents referred to Caroline Counseling Center.
- Family therapy for parents and siblings of adolescents treated by the Caroline Counseling Center.
- Prevention programs in all county schools.

Carroll County

Filling the present gaps in the treatment continuum would require:

1. Expanding sub-acute medically managed detoxification and out-patient detoxification services.

2. Developing partial hospitalization services for clients able to receive intensive outpatient services but who also require housing.

3. Developing long-term care as an alternative to incarceration for young addicted offenders, many of whom are heroin addicted and require more intensive care as well as wrap-around services.

4. Expanding halfway house services for both women and men.

Enhancing existing services would require:

1. Hiring additional staff, including social workers, a physician, addictions counselors, a nurse practitioner, and increased psychiatrist time.

2. Increasing funding for psychiatric medications in order to properly treat clients with co-occurring mental health and substance abuse disorders.

Cecil County

1. Developing medically managed inpatient detoxification services.

2. Expanding adolescent and adult residential treatment services, particularly services for women with children.

Charles County

1. Increasing access to residential treatment, in particular for uninsured individuals and ex-offenders transitioning from the criminal justice system.

2. Increasing access to halfway house placements and establishing additional halfway house placements for individuals with co-occurring alcohol and drug problems and mental illness.

3. Establishing intensive outpatient services as a treatment option for clients leaving residential treatment. Including ambulatory detoxification services if possible.

4. Continuing and expanding support for jail-based treatment services.

5. Establishing an interagency initiative for adolescent intensive outpatient services. This would require 2 addictions counselors to provide comprehensive assessments, drug testing, individual and group counseling, and family intervention services to students in the alternative school or in the Charles County public school system.

Dorchester County

1. Developing local detoxification services. The only detoxification services available to Dorchester County are in Ellendale, Delaware, and the wait for these services can be several weeks.

2. Expanding access to residential treatment services and expanding length of stay for these services to improve treatment outcomes.

3. Developing long-term residential and halfway house placements for both men and women.

Frederick County

1. Developing ambulatory detoxification services.

2. Increasing staffing at the Detention Center treatment program.

3. Supporting and Expanding school-based prevention programming.

4. Increase staffing in order to expand services at the methadone program.

5. Increasing the availability of psychiatric consultation for clients with co-occurring disorders who receive treatment from a range of alcohol and drug treatment programs.

Garrett County

1. Establishing comprehensive drug testing capability. The need exists for a low-cost, easily accessible, comprehensive facility to provide urinalysis drug testing. Drug testing is being used by several different public and private entities, including public and private employers, the criminal justice system, and the treatment system. One facility providing urinalysis could develop a proper and universally accepted protocol that would meet the needs of all local consumers of this service.

2. Increasing access to supportive housing. The county supports the development of a halfway house in Allegany County that could serve Allegany and Garrett County residents. A voucher system to increase access to temporary shelter also would help serve clients who are recently detoxed or released from the criminal justice system.

3. Increasing the size of the clinical staff by two additional Addictions Counselors.

4. Increasing support for training opportunities, especially training in treating special populations, including incarcerated women, the elderly, and the dually diagnosed, and special issues, such as treating chronic relapse.

5. Establishing separate and discreet financial support for the Garrett County Addictions Advisory Council.

6. Establishing a physician service contract with a local physician to provide consultation and treatment to drug treatment clients. This service is particularly necessary given the frequent therapeutic use of medications, including antabuse and methadone, and the need for detoxification referrals.

Harford County

1. Creating a County Health Department rapid assessment and referral unit which would process all referrals from police, courts, service agencies, schools, health care providers, and others and assess and refer clients to appropriate treatment within 10 days.

2. Increasing access to methadone treatment by adding 30 methadone slots.

3. Increasing access to outpatient treatment by adding 150 outpatient slots.

4. Continuing funding for the jail-based treatment program.

5. Increasing access to residential treatment by purchasing slots from local providers.

6. Doubling the capacity of the drug court.

7. Establishing a case management system.

Howard County

1. Expanding social detoxification services.

2. Expanding residential and intermediate care treatment.

3. Expanding halfway house slots, including slots for adolescents, pregnant women and women with children.

4. Providing transportation for clients.

Kent County

1. Expanding access to adolescent treatment services.

2. Expanding detoxification services.

3. Expanding wrap-around and supportive services for women with children. These services would include:

   - Halfway house expansion
   - Parenting courses
   - Child care for women participating in treatment.

4. Expanding intermediate care treatment.

5. Expanding school-based counseling for at-risk adolescents in high school and middle school.

Montgomery County

1. Expanding residential services for adults with co-occurring mental health and substance abuse disorders.

2. Expanding services for adolescents by converting a community-based group home to a halfway house that includes family therapy and psychiatric services for clients with co-occurring disorders.

Prince George's County

1. Increasing inpatient detoxification services for patients who need to be medically supervised during withdrawal prior to admission to a residential program.

2. Expanding the Children and Parents (CAP) Residential Program for women, including pregnant women, who need intensive on-going treatment, support, parenting skills, vocational education, and child care.

3. Expanding the Children and Parents (CAP) Day Program for women who need daily treatment and support services, but who live in the community.

4. Developing transitional housing with the Department of Social Services. This housing would serve women and women with children who require safe, sober and permanent housing during the course of their treatment.
5. Expanding primary drug prevention services.

6. Expanding residential treatment services.

7. Expanding intensive outpatient treatment services.

8. Expanding treatment services for adolescents.

9. Developing specialized services for clients dually diagnosed with mental health and substance abuse disorders.

Queen Anne's County

1. Establishing drug treatment services at the county detention center. To help provide addictions assessment, treatment and referrals for both the general population and for inmates with co-occurring disorders an addictions coordinator is necessary.

2. Establishing comprehensive treatment for adolescents and their families.

3. Establish acupuncture services as a complement to drug treatment services.

Somerset County

1. Expanding services for individuals with co-occurring mental health and addiction disorders.

2. Establishing detoxification services that would serve Somerset as well as other lower Eastern shore counties.

3. Increasing access to long-term residential treatment (six month minimum length of stay.)

St. Mary's County

1. Establishing a jail-based treatment program.

2. Expanding access to intensive outpatient services for adolescents.

3. Establishing case management of addicted youth involved in the criminal justice system.

4. Establishing court-mandated assessment of family violence offenders for alcohol and drug problems.

5. Increasing access to residential treatment services for adults and adolescents, including:

   - An intensive 14 day assessment and diagnostic program for adolescents
   - An adolescent intermediate care facility
   - Non-hospital detoxification services for adults

6. Expanding prevention and intervention services for various populations, including:

   - Children of incarcerated parents
   - Middle school students
   - College students
   - Students served by the Maryland Student Assistance Programs

Talbot County

1. Establishing a regional detoxification center. Presently the only resource for detoxification is the Kent-Sussex Detox Center in Ellendale, Delaware. This center provides only two beds for Maryland residents.

2. Establishing access to publicly-funded intermediate level rehabilitation.

3. Establishing a publicly-funded adolescent rehabilitation facility to serve all nine Eastern shore counties.

4. Creating halfway house placements for adults and adolescents.

5. Increasing access to training both for alcohol and drug treatment staff and local public agency staff, including teachers, police officers, and probation officers.

6. Updating and increasing access to public education materials and public campaigns about treatment to increase referrals.

7. Increasing access to child care for women in treatment.

8. Acquiring funds to cover treatment for uninsured individuals and individuals covered by Health Maintenance Organizations that do not provide coverage for alcohol and drug treatment.

9. Establishing a jail-based treatment program. The county presently is seeking grant funding for this program, but needs additional funds to cover the cost of urine testing and a part-time counselor.

10. Acquiring funds to cover one-time expenses related to building and moving to a permanent health department addictions treatment facility.

Washington County

1. Developing an ambulatory detoxification program.

2. Expanding jail-based treatment services.

3. Supporting halfway house services for women and expanding these services by making them available to women with children.

Wicomico County

1. Establishing a case management system to help clients gain access to ancillary and wrap-around services and negotiate the system of care.

2. Increasing the presence of social workers in drug treatment programs to add knowledge and assessment in the related areas of social programs, family systems, and community systems.

3. Establishing a drug treatment assessment system in the court. This project would entail having addictions counselors on site at the courthouse to screen and assess offenders for drug and alcohol problems. The assessors would make a recommendation to the court about placement in treatment and provide a referral to treatment.

4. Establishing drug courts for first-time offenders.

5. Establish access to long term treatment on the Eastern Shore.

6. Establish access to intensive outpatient services for uninsured county residents.

7. Establish access to detoxification services on the Eastern Shore.

Worcester County

1. Establishing access to detoxification services for the lower Eastern Shore.

2. Establishing comprehensive treatment for adolescents. The need for adolescent treatment is rising rapidly. Referrals to the Health Department's clinics rose 63% between FY 93 and FY 96. To handle the increased demand for these services, the following programs are necessary:

   - A family treatment component that targets the whole family.
   - An intensive outpatient program lasting 6-10 weeks, for 6 hours a week. Clients would participate in counseling, education, and self-help meetings.
   - Ambulatory detoxification services
   - Aftercare services
   - Employment and/or educational opportunities.

3. Continuing and expanding support for the Worcester County Health Department's Addic-

tions Cooperative Services, which supplies space for addiction treatment, self-help meetings, and socialization for individuals in recovery and their families.

Task Force Recommendations

Based on information gathered through the needs assessment process, the Task Force recommends the following use and distribution of tobacco settlement funds:

- **Tobacco settlement funds should be spent on three critical activities:**
  - **Filling in treatment system gaps.**
  - **Boosting treatment system salaries.**
  - **Increasing system accountability.**
- **This spending strategy both increases access to and improves the effectiveness of drug treatment services.**
  - **The majority of tobacco settlement funding for drug treatment should increase access to services and treatment system salaries.**
  - **Approximately $1.3 million of the tobacco settlement funds should support treatment system improvement.** Activities supported by these funds would include:
    - Developing a performance measure system to report program and treatment effectiveness.
    - Developing an information management system that links assessments, placements and other critical shared data.
    - Continuing the work of the Drug Treatment Task Force over the next year so that it can complete the development of a statewide, comprehensive drug treatment system.
- **Tobacco settlement funds should be distributed so that every region of the state can improve some aspect of its drug treatment continuum.**
  - The Maryland Drug Treatment Task Force, based on the needs assessment, will indicate to the Alcohol and Drug Abuse Administration the types of services that would fill a gap in the treatment continuum in each local jurisdiction or region.
  - The Drug Treatment Task Force, in consultation with the Alcohol and Drug Abuse Administration, should have the discretion to direct some tobacco settlement funds to statewide or regional drug treatment programs serving multiple jurisdictions in the state.
  - The Alcohol and Drug Abuse Administration should administer tobacco settlement funds to each jurisdiction/region for the identified services.
- **Tobacco Settlement funds should be spent on effective programs that have demonstrated**

their ability to treat clients in Maryland.

- To help ensure that tobacco settlement funds are spent most effectively, counties should invest funds to expand services offered by programs presently and successfully serving local Maryland communities, or that are best situated to serve a community if a modality of treatment is not presently available.

- When investing funds, counties should give preference to:

  - Historic, community-based alcohol and drug treatment providers.
  - Programs that offer or are connected to wrap-around services, such as educational instruction, employment training, parenting classes, health services, transitional housing, and transportation.

- **Accountability for fund expenditure is paramount to help ensure valuable system expansion and improvement.**

  - Before receiving tobacco settlement funds, counties should report to the Maryland Drug Treatment Task Force and the Alcohol and Drug Abuse Administration the specific programs and services in which they plan to invest the funds. The plan should specify the amount of funds to be spent on each program and service expansion.

  - Treatment programs receiving funds should:

    - Use a standardized assessment instrument to ensure clients are matched with appropriate treatment services.
    - Ensure that clients are referred and placed into the next appropriate level of care after completion of their treatment program.
    - Incorporate evaluation techniques, such as drug testing, into program and client evaluation activities.

Apppendix D

[redacted] Lt. Governor Kathleen Kennedy Townsend (Chair),
Delegate Dan K. Morhaim, M.D. (Co-Chair)
&
The Maryland Drug Treatment Task Force

Invite you to attend

Strengthening our Communities:
Increasing the Availability & Effectiveness of Drug Treatment & Prevention

In its efforts to increase the availability and effectiveness of drug treatment and prevention services throughout the state, the Maryland Drug Treatment Task Force will be holding 4 public hearings.

Baltimore Regional Hearing
Monday, April 24, 2000
6:00-9:00 p.m.
War Memorial Hall, 1st Floor
(Located across the street from City Hall)
101 North Gay St.
Baltimore, Maryland

Hagerstown Regional Hearing
Thursday, May 25, 2000
2:30-5:30 p.m.
Hagerstown Community College, Kepler Theater
11400 Robinwood Drive
Hagerstown, Maryland

College Park Regional Hearing
Monday, June 5, 2000
6:00-9:00 p.m.
University of Maryland, College Park
Physics Building, Lecture Hall (Rm. 1412)
College Park, MD

Salisbury Regional Hearing
Tuesday, June 20, 2000
1:00-4:00 p.m.
Wicomico Civic Center
500 Glen Avenue
Salisbury, MD

***For more information about the Maryland Drug Treatment Task Force please email drugtaskforce@dhmh.state.md.us or phone 301-670-1214.**

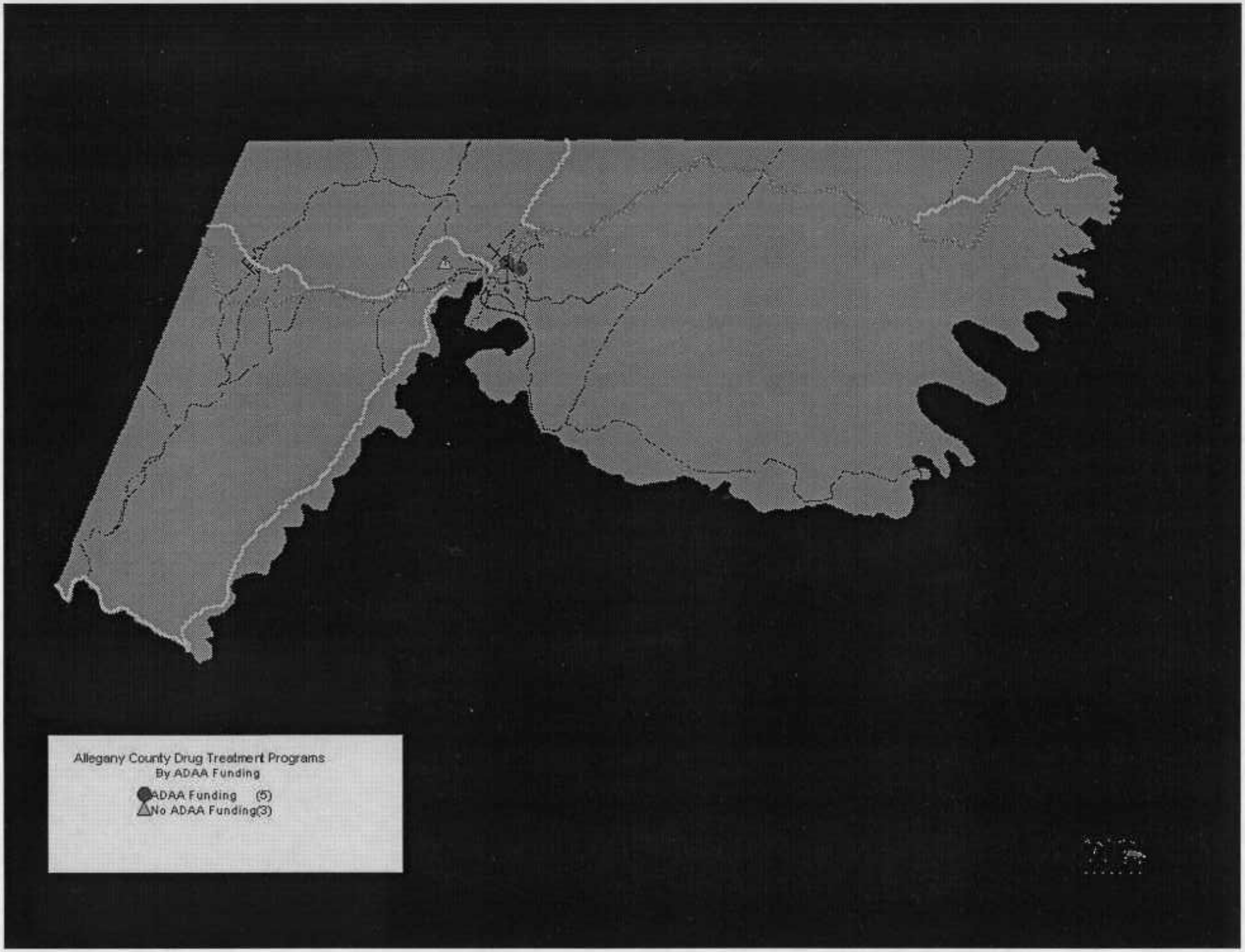
Appendix E

Inventory of Alcohol and Drug Treatment Programs Certified by the State of Maryland as of October, 2000[1,2].

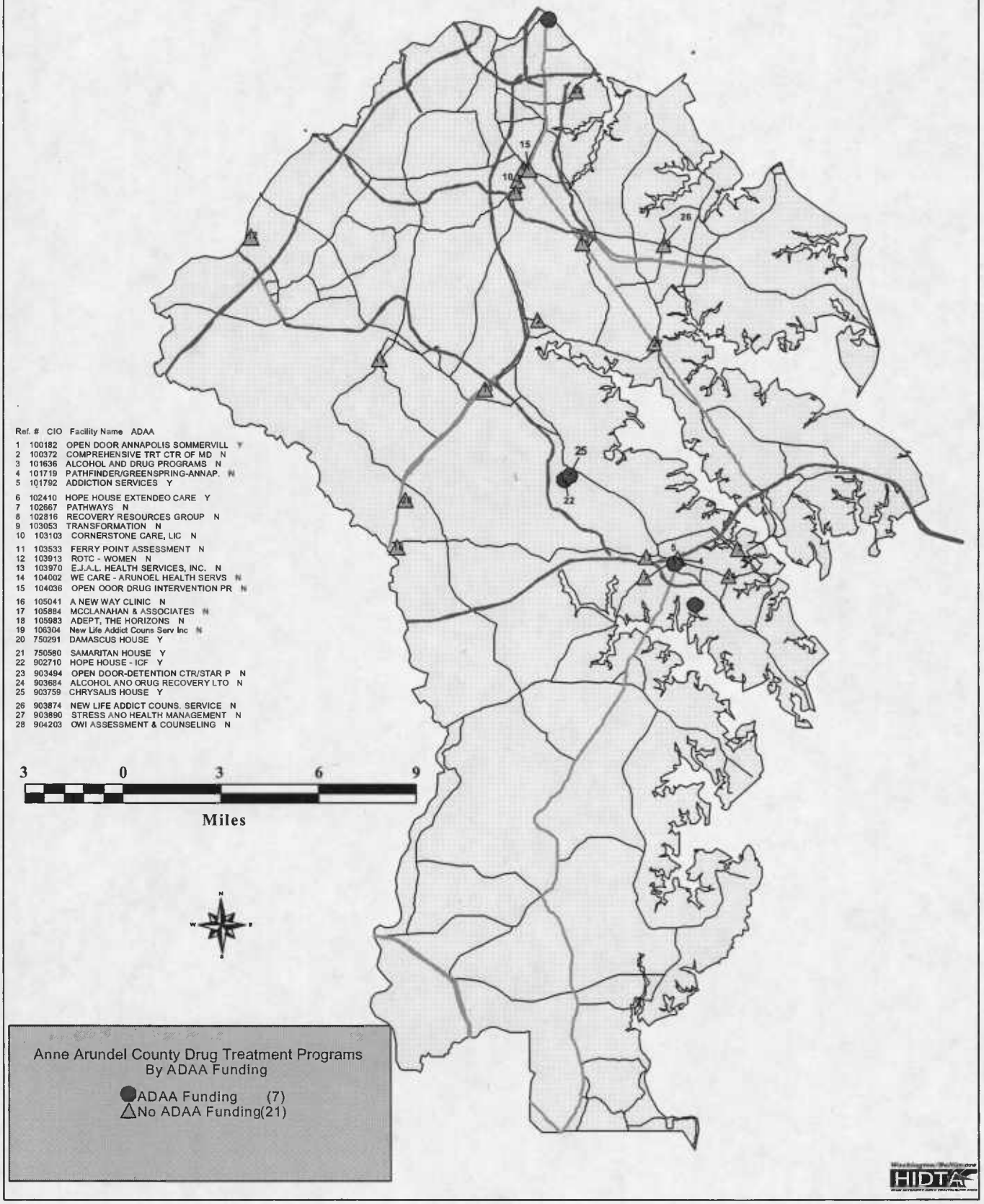
COUNTY	Total Programs	Outpatient		MAT		Health Dept		Halfway House		ICF		Correctional		IOP		MAT & ODF		Residential		Long term Residential		Non-hosp Detox		Group Home	
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	
Allegany	8		2			1				3			1	1											
Anne Arundel	28		15	2		1	1	3		1	1		1			1		1		1					
Baltimore	35	8	21	1		1							2	2											
Calvert	7		1			4							2												
Caroline	1					1																			
Carroll	10	1	3		1	1				2			1		1										
Cecil	3		1			1		1																	
Charles	2					1															1				
Dorchester	5		1			1					1		1	1											
Frederick	20		10		1	1		2		1	2		1			1								1	
Garrett	3					1							1						1						
Harford	9		4		1	1		1			1					1									
Howard	11		6		1	1							3												
Kent	2					1				1															
Montgomery	33	4	18		3			1	1	1	1	1				1		1				1			
Prince Georges	29	2	19		2				1	1						2		1	1						
Queen Anne's	1					1																			
St. Mary's	4	1	1					1																1	
Somerset	2					1							1												
Talbot	2		1			1																			
Washington	11		3			1		1	1		1	1	2	1											
Wicomico	9		4					1		1				1	1	1									
Worcester	1					1																			
Baltimore City	93	16	35	10	10			7		2	1		3	2	4				2				1		
TOTAL	329	32	145	13	19	22	1	18	3	13	8	2	19	8	6	7	0	3	4	1	1	1	1	2	

[1]Y denotes ADAA funding vs. N (no ADAA funding); MAT: Medication-assisted Treatment; ICF: Intermediate Care Facility; IOP: Intensive Outpatient; ODF: Outpatient Drug Free

[2]The total number of programs in this table do not exactly correspond with the totals on the more general maps of the treatment programs due to missing data on the type of facility at the time this table was constructed.

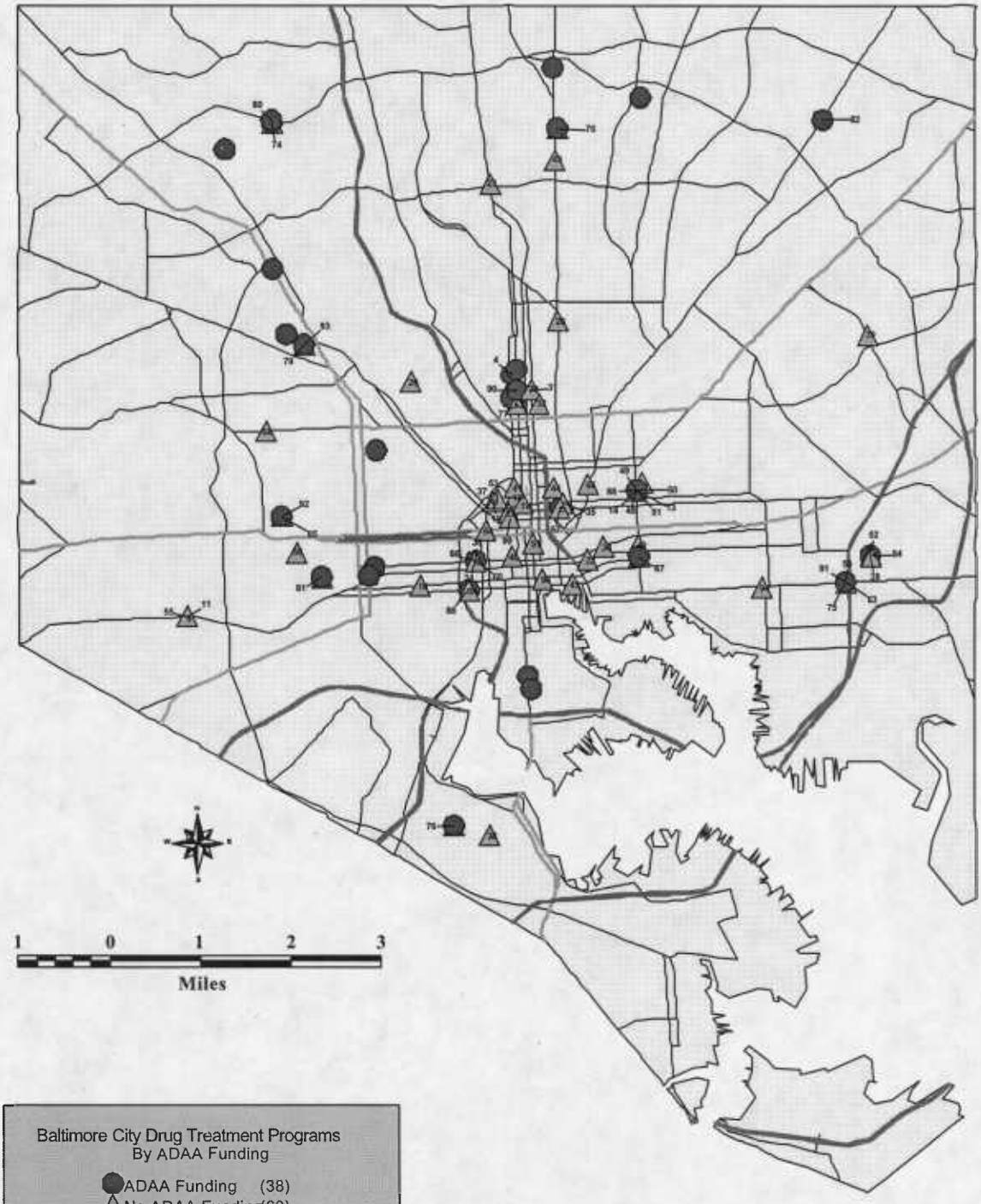

Allegany County Drug Treatment Programs
By ADAA Funding
ADAA Funding (5)
No ADAA Funding(3)

Anne Arundel County



February, 2001

Baltimore City



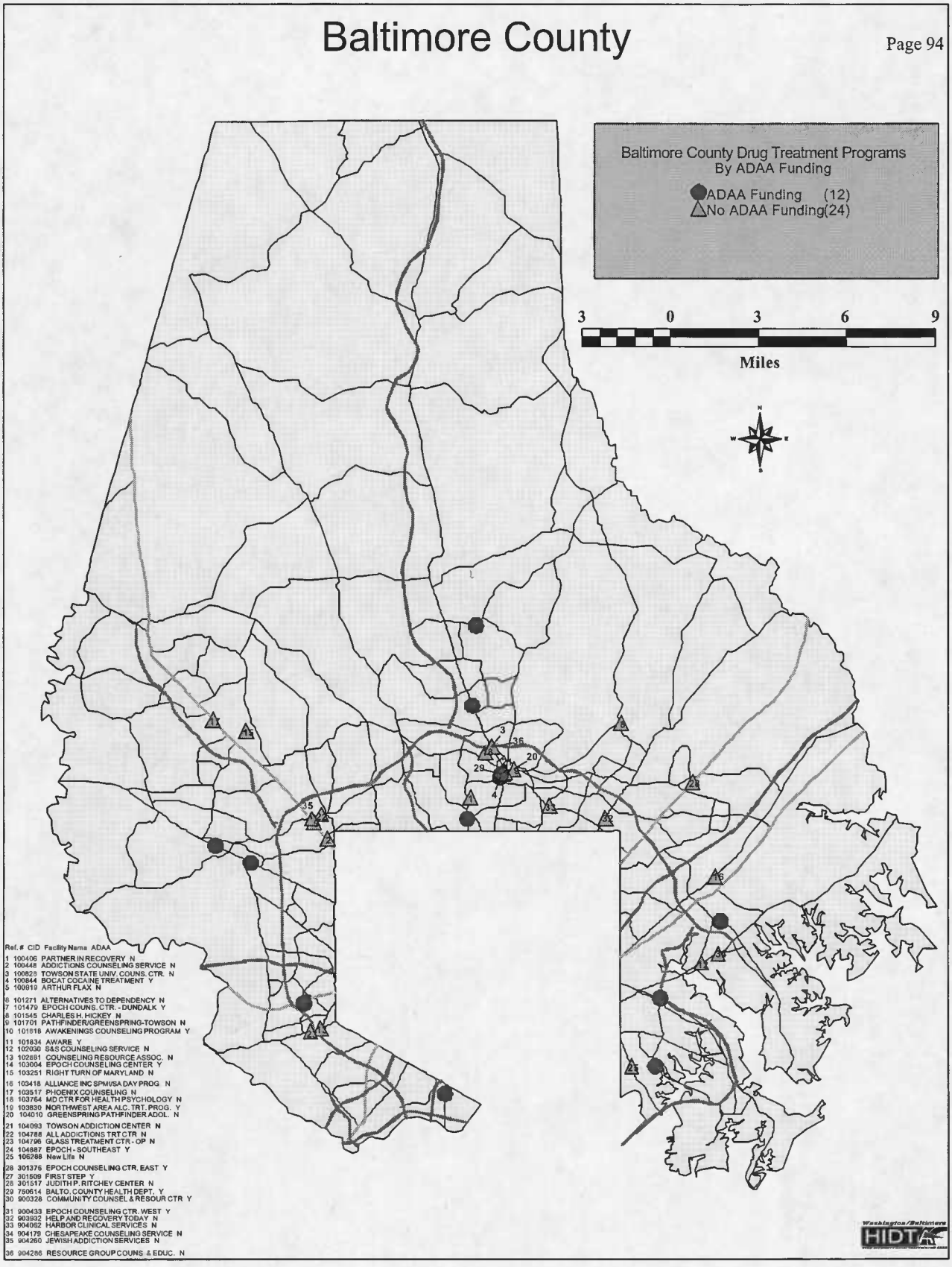
Baltimore City Treatment Facilities

Ref. No.	Facility	ADAA Funded
1	SOUTHEASTERN DEPT. OF PSYCHIATRY & MEDICINE	Y
2	ECHO HOUSE	Y
3	UNIV. OF MD, DRUG TREATMENT	Y
4	ADDICT REFERRAL & COUNSELING	Y
5	REFLECTIVE TREATMENT CENTER	Y
6	JOHNS HOPKINS HOSPITAL	Y
7	DEAF SUBSTANCE ABUSE TRT SERVS	Y
8	MOUNTAIN MANOR – BALTIMORE	N
9	GLASS SUBSTANCE ABUSE PROG.	N
10	BBH - INTENSIVE OUTPATIENT	N
11	MOUNTAIN MANOR TREATMENT CTR.	N
12	UNIVERSAL COUNSELING SERVICES	N
13	JOHNS HOPKINS - WOMENS INTENSIVE OUTPATIENT	Y
14	JOHNS HOPKINS - WOMENS OUTPATIENT	Y
15	QUARTERWAY OUTPATIENT CLINIC	N
16	IBR MOBILE HEALTH SERVICES	Y
17	BRIGHT HOPE HOUSE	Y
18	NEW OUTLOOK	N
19	CROSSROADS CENTERS	N
20	WILLIAM DONALD SCHAEFER HOUSE	N
21	CENTER FOR ADDICTION PREGNANCY	N
22	HARBOUR CENTER	N
23	LOYOLA COLLEGE ALCOHOL/DRUG	N
24	UNIV. OF MD CARTER CENTER ADAP	N
25	POWELL RECOVERY CENTER	N
26	PEOPLE'S COMMUNITY ADDICTIONS	N
27	NEW HOPE - NEEDLE EXCHANGE	N
28	SOUTHEASTERN - NEEDLE EXCHANGE	N
29	STITH AND ASSOCIATES	N
30	GBMC WEINBERG COMM HLTH CTR	N
31	AWELE TREATMENT AND REHAB.	N
32	RE-ENTRY AFTERCARE/GUILFORD AV	N
33	RE-ENTRY AFTERCARE/MONUMENT ST	N
34	MSAAP(MATERNAL ACUPUNCTURE PR)	Y
35	BCDC MALE SUBSTANCE ABUSE PROGRAM	N
36	UNIV OF MD NEEDLE EXCHANGE PROGRAM	N
37	METHADONE FOR BUSINESS ACHIEVERS	N
38	SOUTH BALTIMORE FAMILY CENTER	N
39	TURNING CORNERS	N
40	HEALTH CARE FOR THE HOMELESS	N
41	CHASE-BREXTON HEALTH SERVICES	N

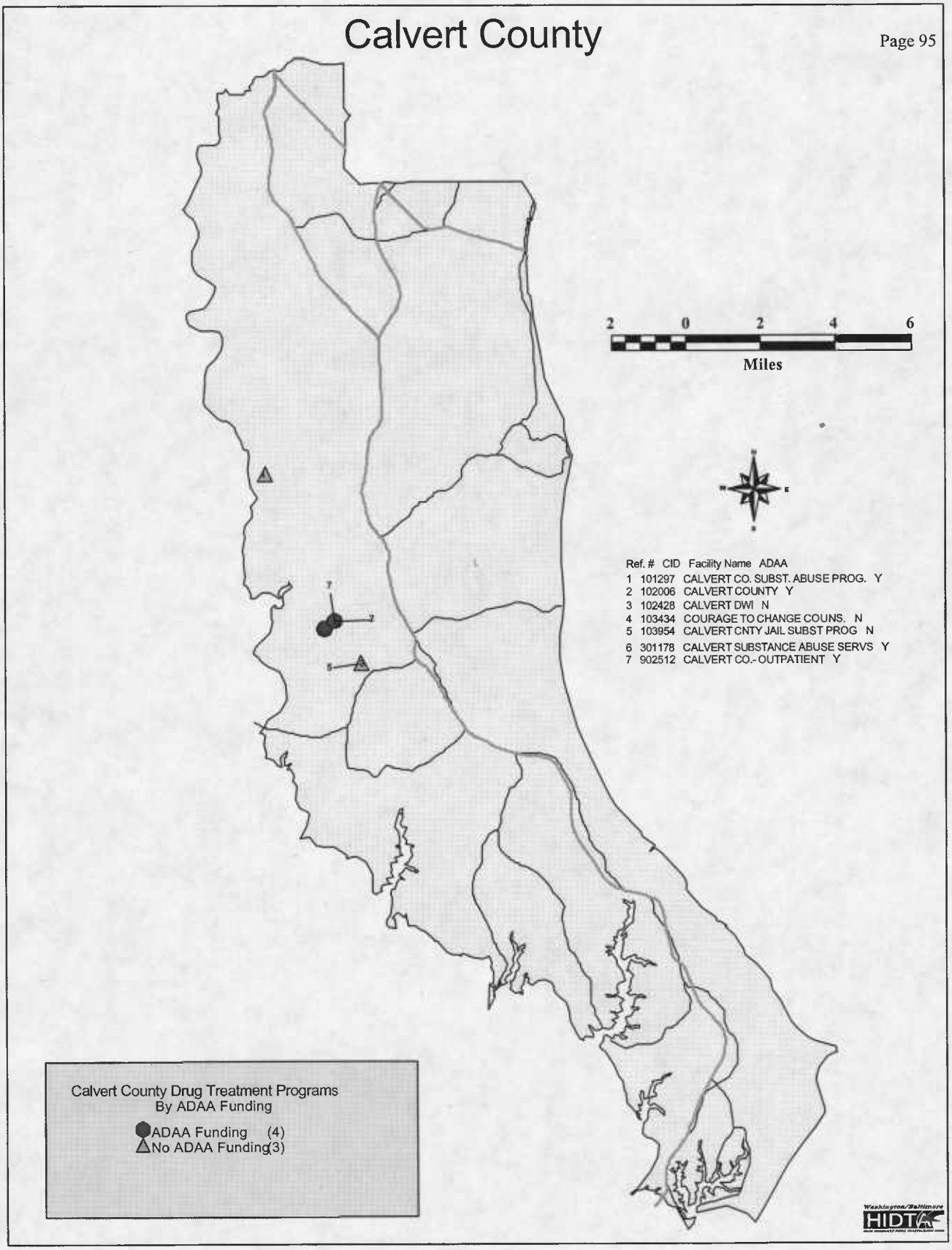
Ref. No.	Facility	ADAA Funded
42	ATLANTIC COAST EVAL & RECOVERY	N
43	JAI MEDICAL CENTER	N
44	BCDC FEMALE SUBST ABUSE PROG	N
45	RECOVERY NETWORK	N
46	HARAMBEE TREATMENT CENTER	Y
47	OVERCOME – DETOX	N
48	JHH BROADWAY CTR - IOP NON-FUNDED	N
49	JHH BROADWAY CTR - OP NON-FUNDED	N
50	JHH CWC -IOP NON-FUNDED	N
51	JHH CWC - OP NON-FUNDED	N
52	SOUTHEAST BALTIMORE MANAGED CARE ORGANIZATION	N
53	CENTER FOR ADDICTION MEDICINE	N
54	SINAI HOSP ADDICTIONS PROG-MANAGED CARE ORG.	N
55	MOUNTAIN MANOR - BALTIMORE OUTPATIENT	N
56	BALTO PRE-RELEASE RESIDENTIAL	N
57	EAST BALTO DRUG/THE CHANCE CENTER	N
58	JH BAYVIEW COMMUNITY PSYC-ADOL	N
59	GATEWAY ADOLESCENT PROGRAM	N
60	EVERLYN JORDON TREATMENT PROG	N
61	GLENWOOD LIFE MANAGED CARE ORGANIZATION	N
62	MAN ALIVE MANAGED CARE ORGANIZATION	N
63	JH BAYVIEW COMMUNITY PSY-ADULT	N
64	RAVENWOOD NURSING & REHAB CENTER	N
65	EAGER STREET SUBS ABUSE CLINIC	N
66	UNIV. OF MARYLAND FEDERAL AFTERCARE PROGRAM	N
67	RIKER MCKENZIE HOLISTIC TREATMENT CENTER	N
68	I CAN'T WE CAN	N
69	TRY	Y
70	GLENWOOD LIFE COUNSELING CENTER	Y
71	HARBEL SUBSTANCE ABUSE SERVICES	Y
72	QUARTERWAY INC. NILSSON HOUSE	Y
73	FAYETTE HOUSE	Y
74	SINAI HOSP. ALCOHOLISM PROGRAM	Y
75	JH BAYVIEW MED CTR. – OUTPATIENT	Y
76	DAYBREAK REHABILITATION	Y
77	MAN ALIVE	Y
78	JONES FALLS COMMUNITY CORP.	Y
79	ADAPT CARES (PROJECT ADAPT)	Y
80	SINAI HOSP. DRUG DEPENDANCY	Y
81	NEW HOPE TREATMENT CENTER	Y
82	HARBEL PREV. & RCOVERY CTR	Y
83	NEXT PASSAGE (LIBERTY MED CTR)	Y
84	BPRU DRUG PROGRAM	N

Ref. No.	Facility	ADAA Funded
85	TUERK HOUSE	Y
86	UNIV. OF MD - ALC. & DRUG IOP	N
87	VALLEY HOUSE	Y
88	JOHNS HOPKINS HOSPITAL	Y
89	FRIENDSHIP HOUSE – HALFWAY HOUSE	Y
90	TOTAL HEALTH CARE	Y
91	JHH BAYVIEW MED CTR. ARC HOUSE	Y
92	QUARTERWAY INC. WEISMAN/KAPLAN	Y
93	OVERCOME (LIBERTY TOWANDA)	Y
94	MOUNTAIN MANOR COUNSELING CENTER.	N
95	NORTHWEST BALTO. YOUTH SERVICE	Y
96	SAFE HOUSE	Y
97	OPERATION RECOVERY	N
98	CONTEMPORARY COUNSELING SERVICES, INC.	N
99	ACTION COUNSELING SERVICES	N

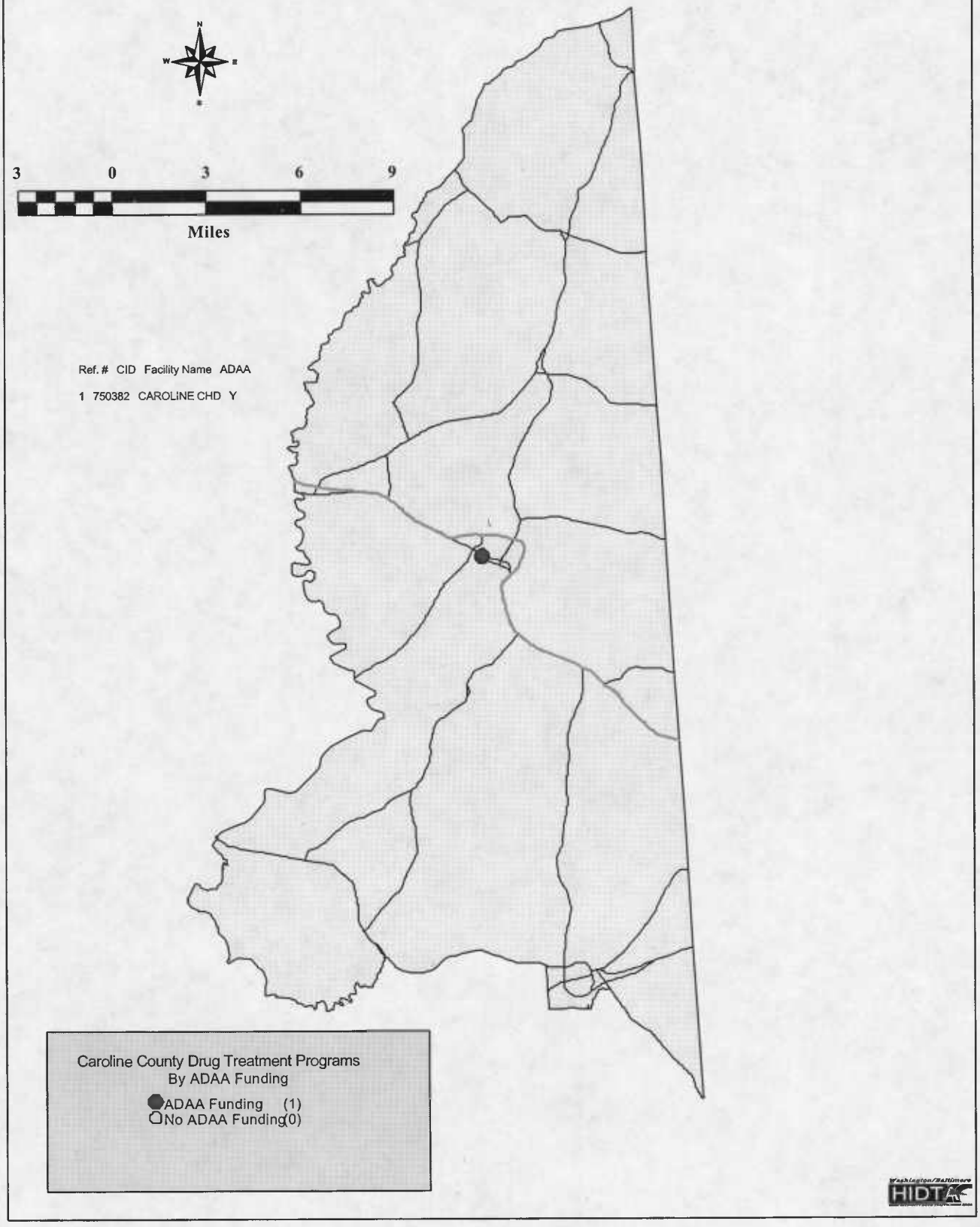
Baltimore County



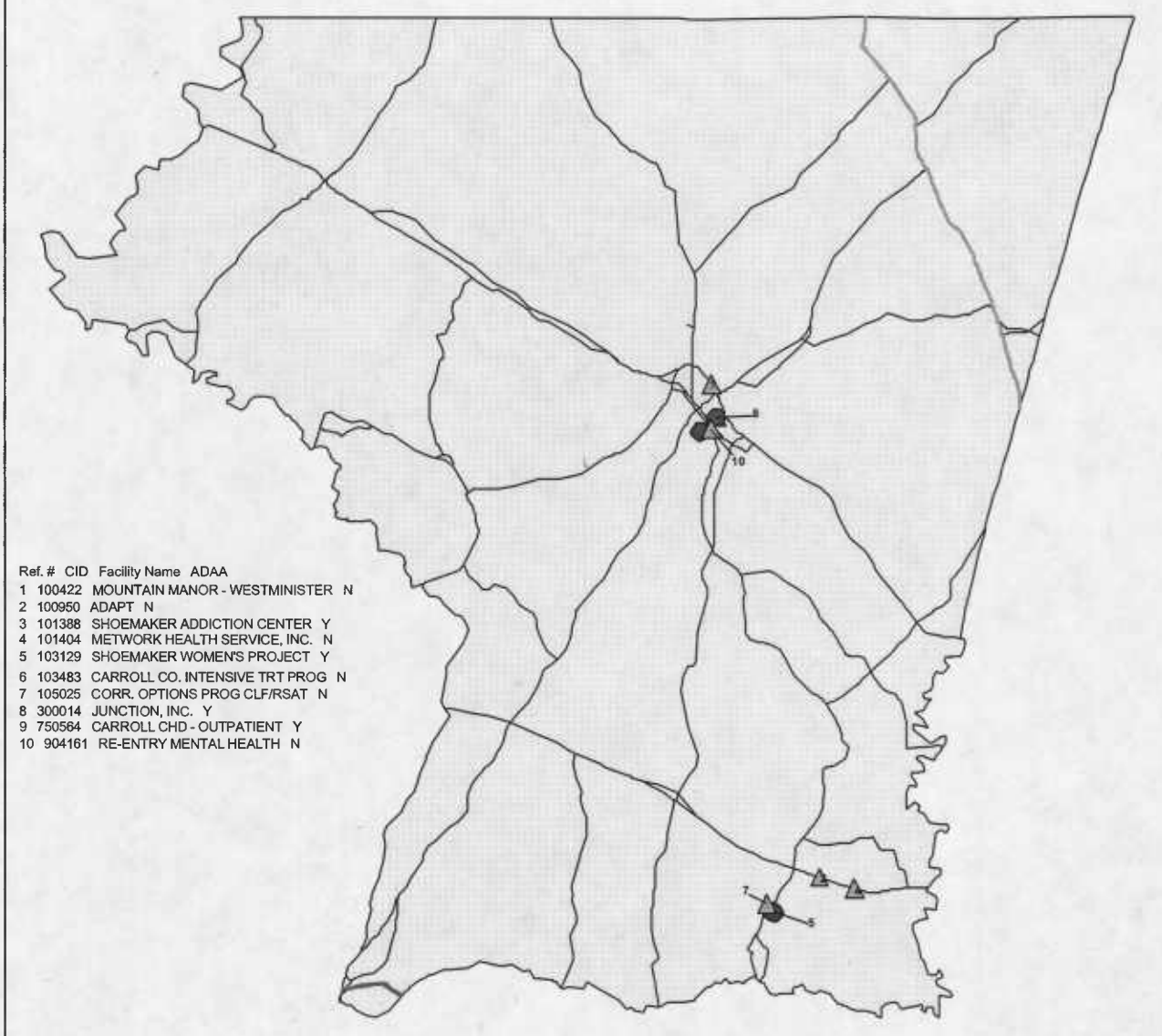
Calvert County



Caroline County



Carroll County



Ref. #	CID	Facility Name	ADAA
1	100422	MOUNTAIN MANOR - WESTMINISTER	N
2	100950	ADAPT	N
3	101388	SHOEMAKER ADDICTION CENTER	Y
4	101404	METWORK HEALTH SERVICE, INC.	N
5	103129	SHOEMAKER WOMEN'S PROJECT	Y
6	103483	CARROLL CO. INTENSIVE TRT PROG	N
7	105025	CORR. OPTIONS PROG CLF/RSAT	N
8	300014	JUNCTION, INC.	Y
9	750564	CARROLL CHD - OUTPATIENT	Y
10	904161	RE-ENTRY MENTAL HEALTH	N

Carroll County Drug Treatment Programs
By ADAA Funding

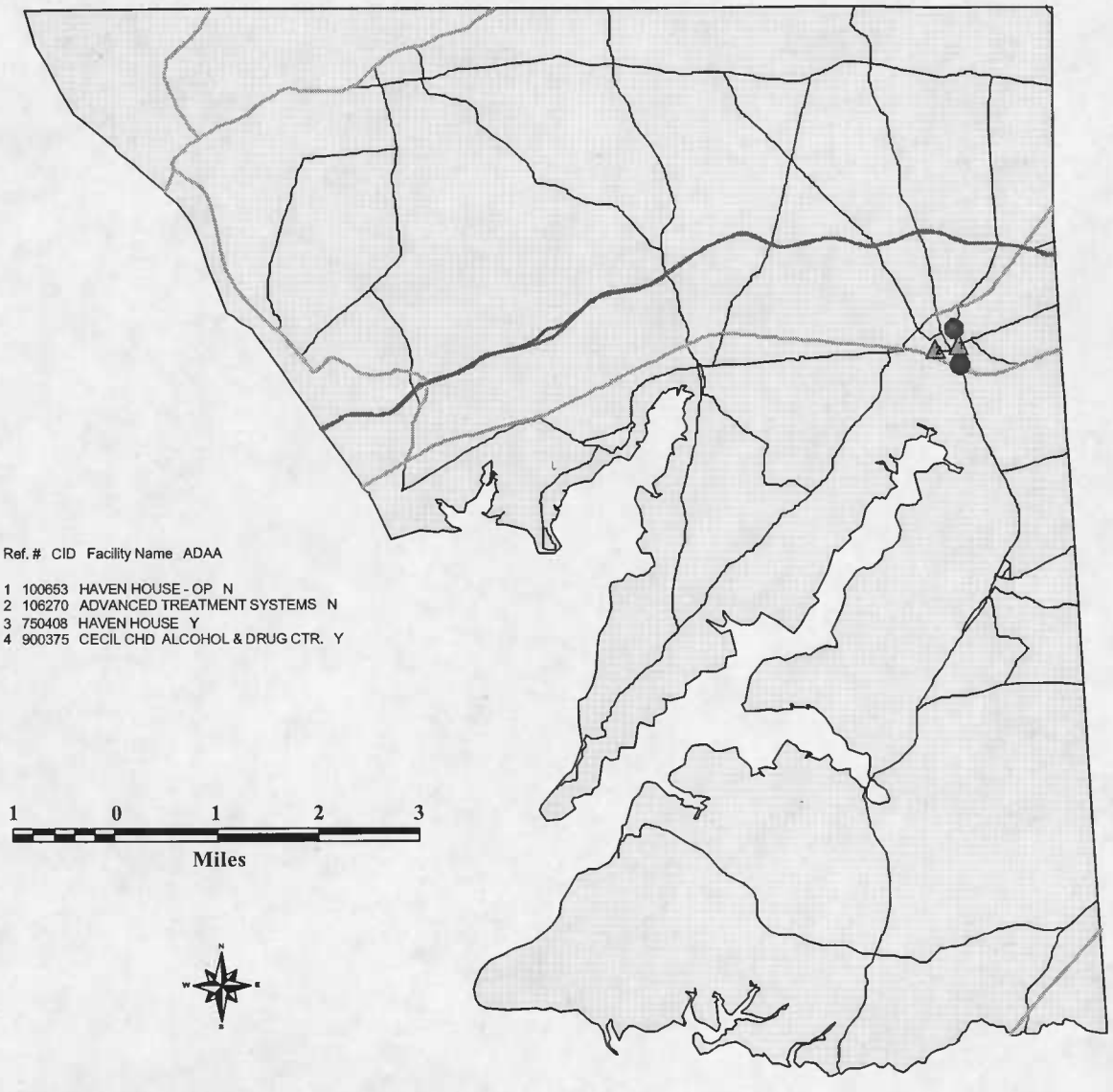
ADAA Funding (4)
No ADAA Funding(6)

3 0 3 6 9

Miles

Washington/Baltimore HIDTA

Cecil County



Ref. # CID Facility Name ADAA

1 100653 HAVEN HOUSE - OP N
2 106270 ADVANCED TREATMENT SYSTEMS N
3 750408 HAVEN HOUSE Y
4 900375 CECIL CHD ALCOHOL & DRUG CTR. Y

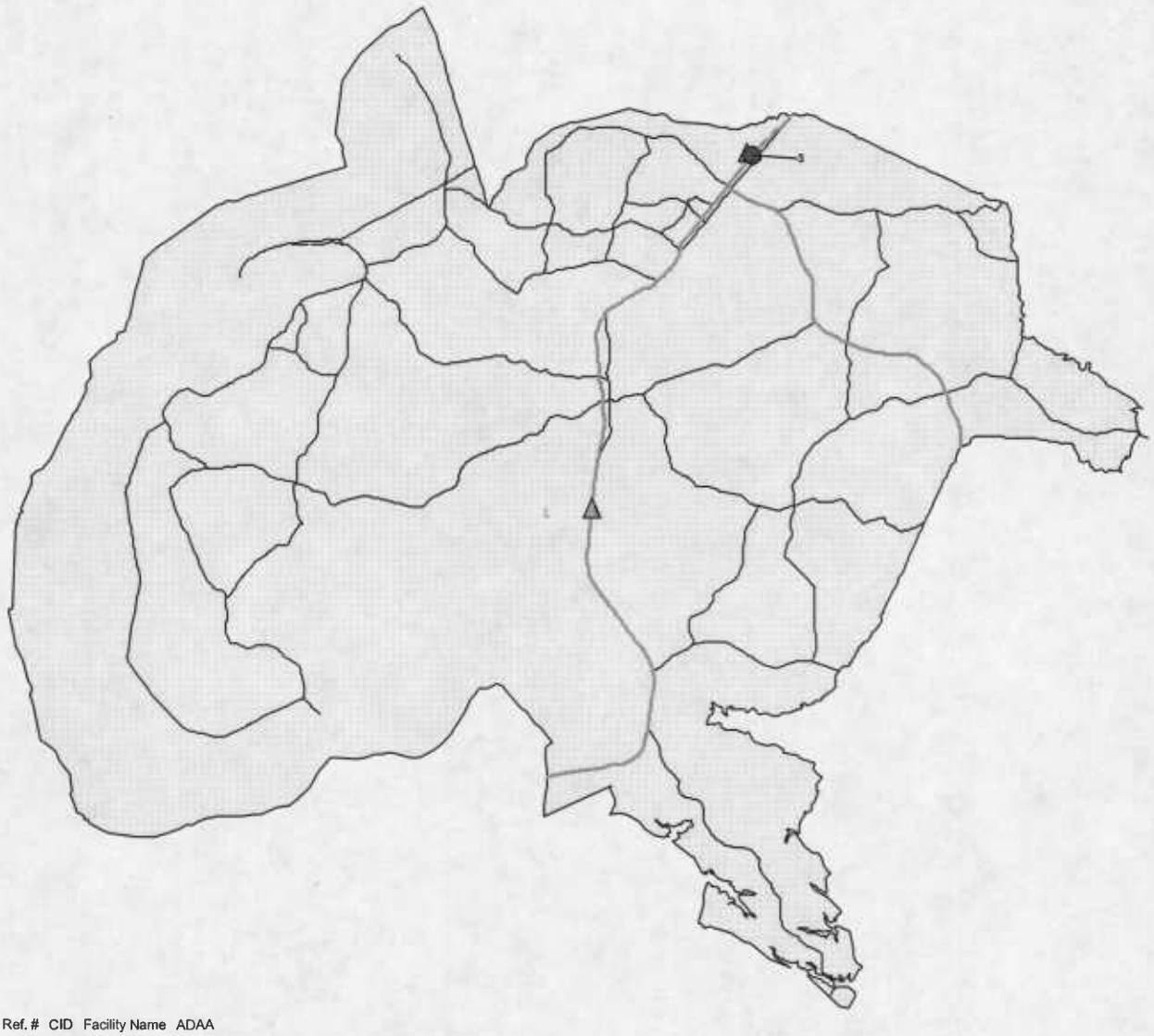
1 0 1 2 3

Miles

Cecil County Drug Treatment Programs
By ADAA Funding

ADAA Funding (2)
No ADAA Funding(2)

Charles County



Ref. # CID Facility Name ADAA

1 102188 JUDE HOUSE N
2 102899 OPEN ARMMS, INC. N
3 750473 CHARLES CHD - OUTPATIENT Y

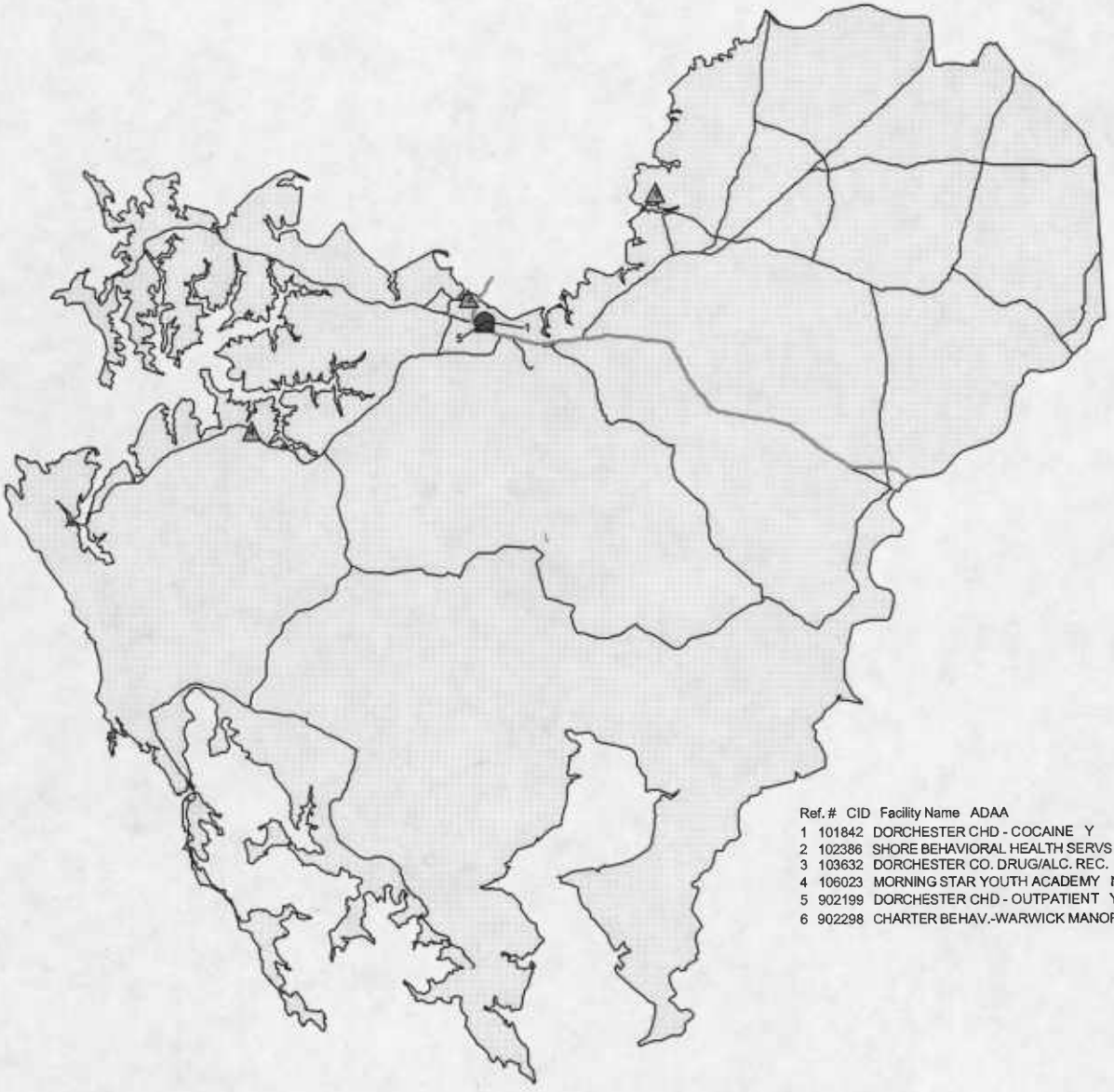
Charles County Drug Treatment Programs
By ADAA Funding

ADAA Funding (1)
No ADAA Funding(2)

4 0 4 8 12

Miles

Dorchester County



Ref. #	CID	Facility Name	ADAA
1	101842	DORCHESTER CHD - COCAINE	Y
2	102386	SHORE BEHAVIORAL HEALTH SERVS	N
3	103632	DORCHESTER CO. DRUG/ALC. REC.	N
4	106023	MORNING STAR YOUTH ACADEMY	N
5	902199	DORCHESTER CHD - OUTPATIENT	Y
6	902298	CHARTER BEHAV.-WARWICK MANOR	N

Dorchester County Drug Treatment Programs
By ADAA Funding

● ADAA Funding (2)
△ No ADAA Funding(4)

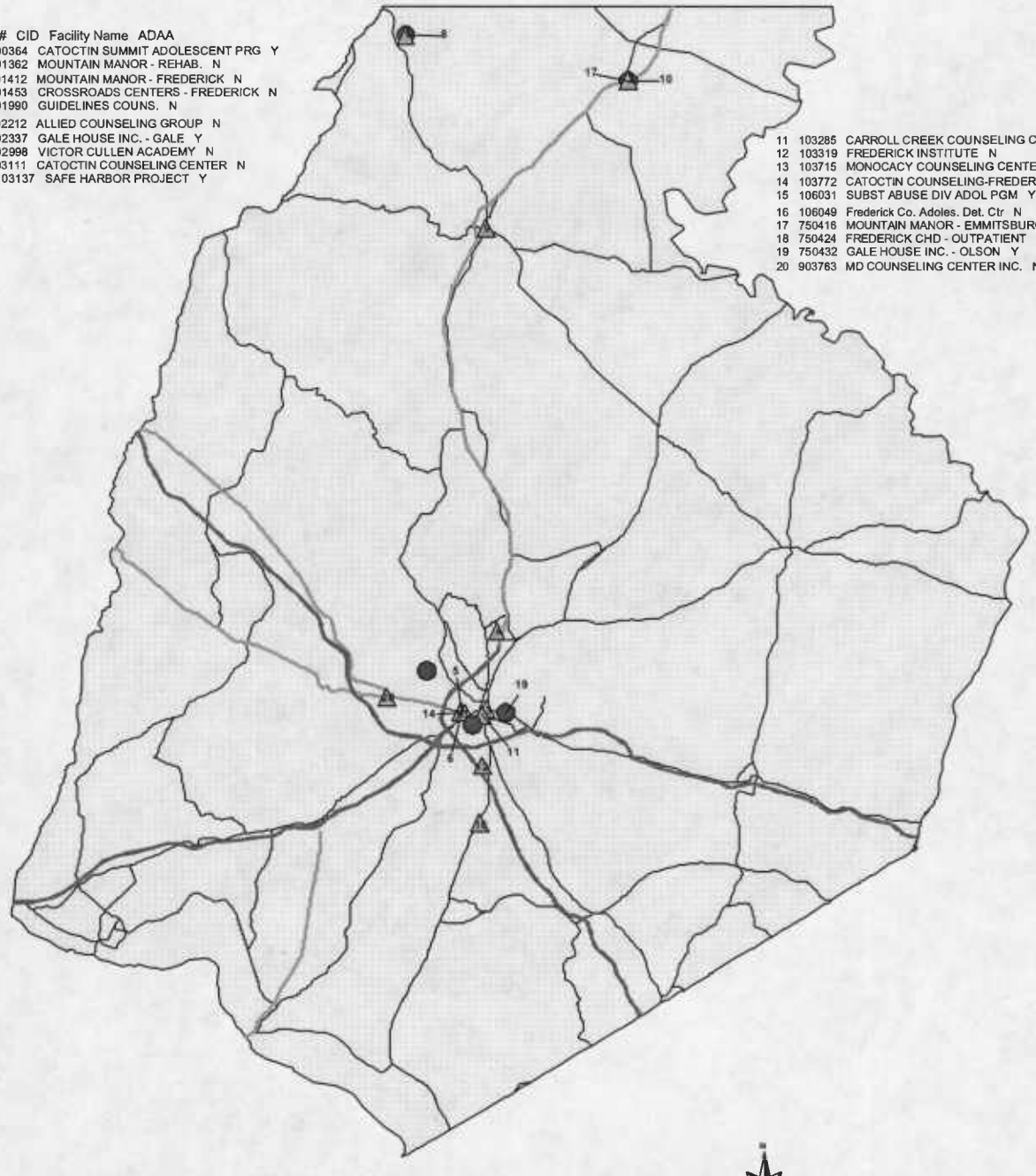
N
W E
S

4 0 4 8 12

Miles

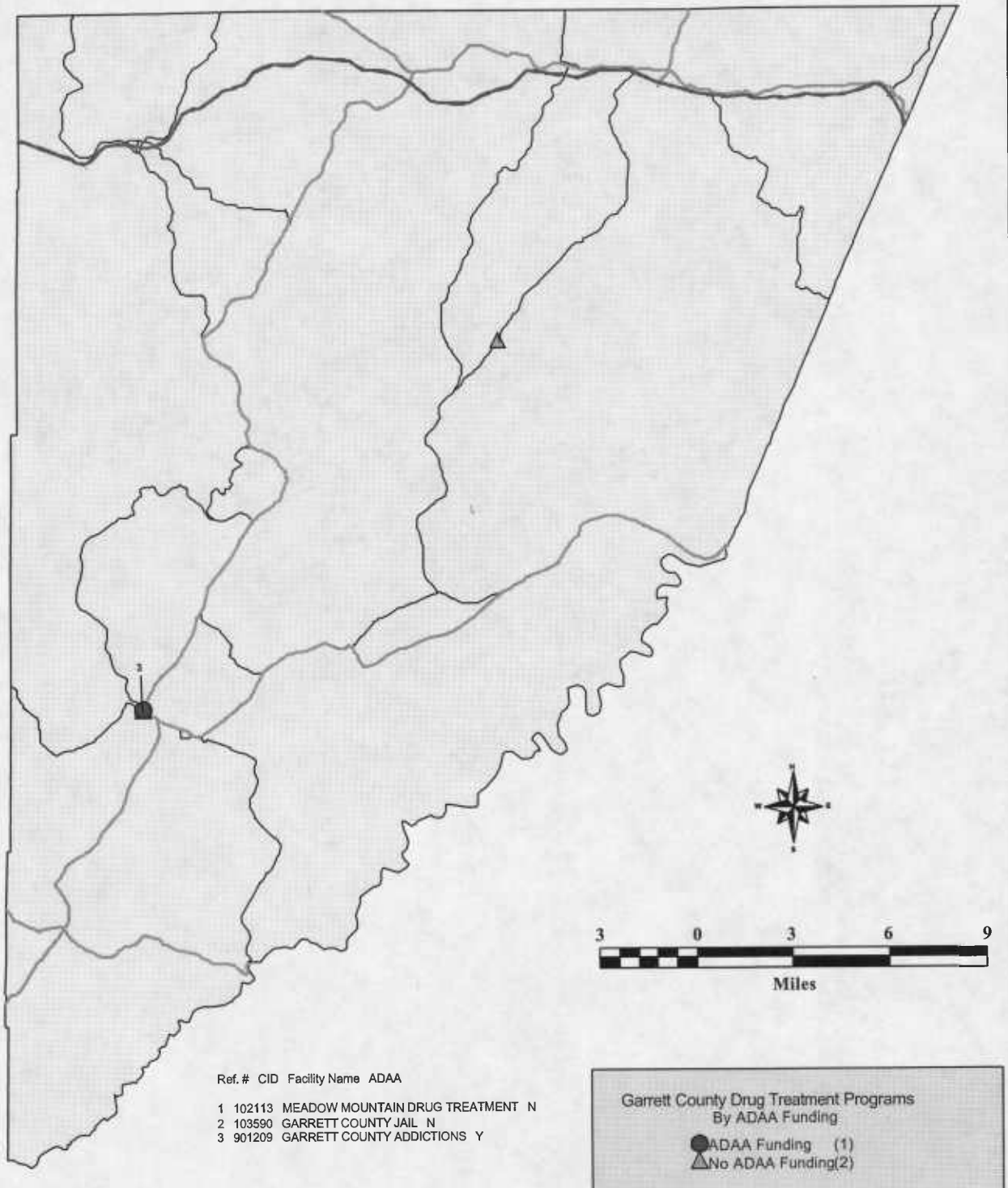
Washington/Baltimore HIDTA

Frederick County



February, 2001

Garrett County



Ref. # CID Facility Name ADAA

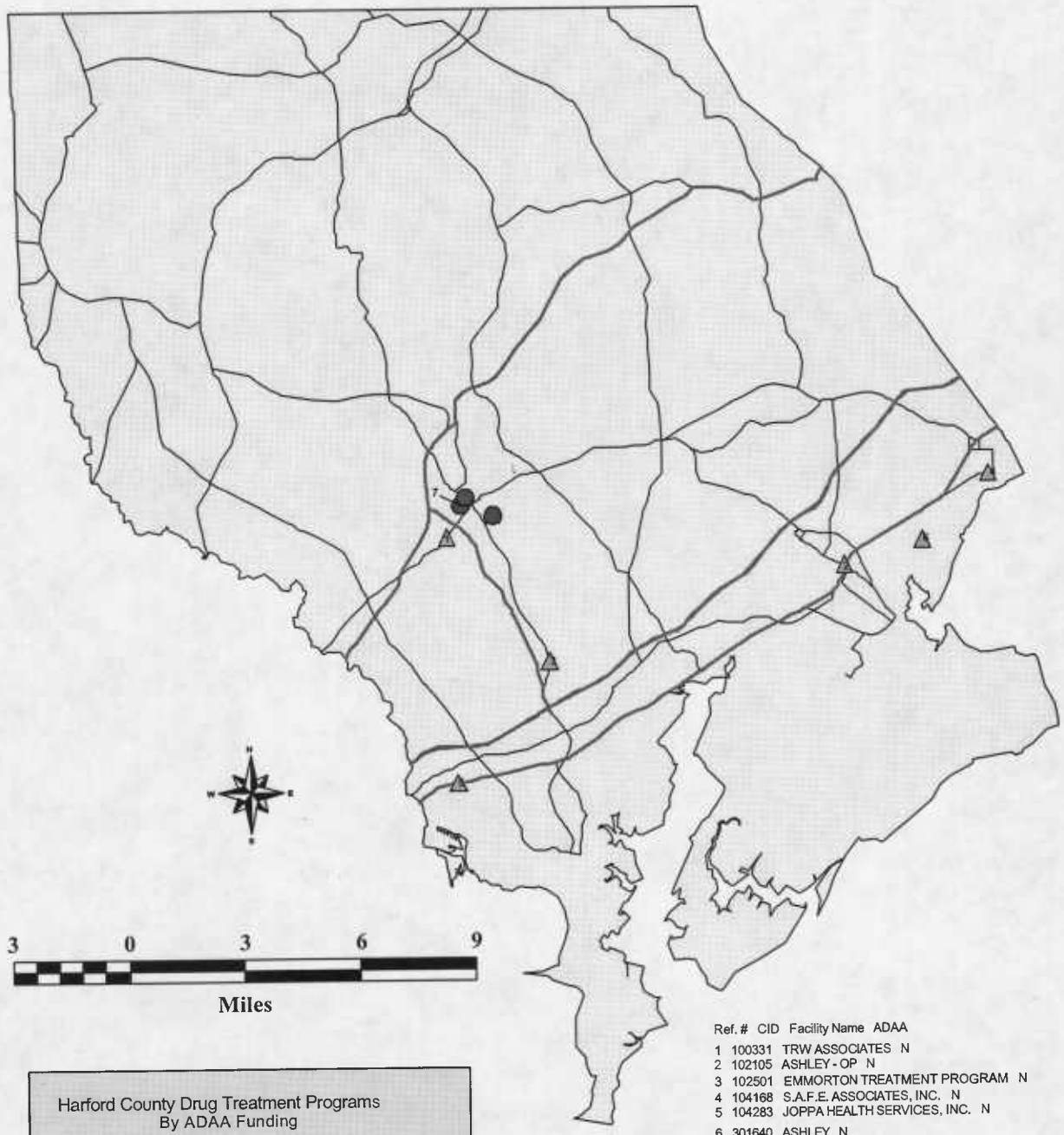
1 102113 MEADOW MOUNTAIN DRUG TREATMENT N
2 103590 GARRETT COUNTY JAIL N
3 901209 GARRETT COUNTY ADDICTIONS Y

Garrett County Drug Treatment Programs
By ADAA Funding

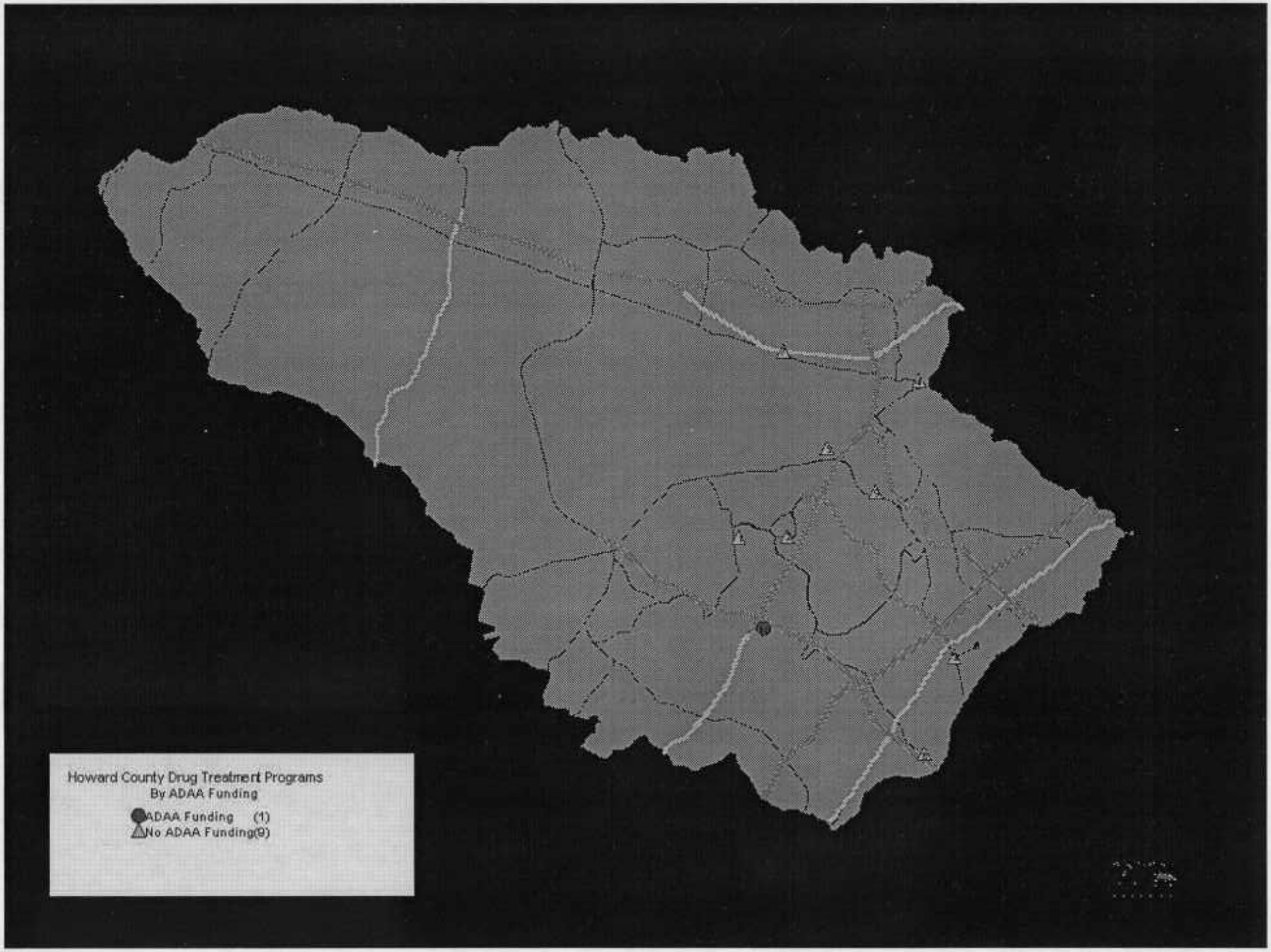
ADAA Funding (1)
No ADAA Funding(2)

Washington/Baltimore HIDTA

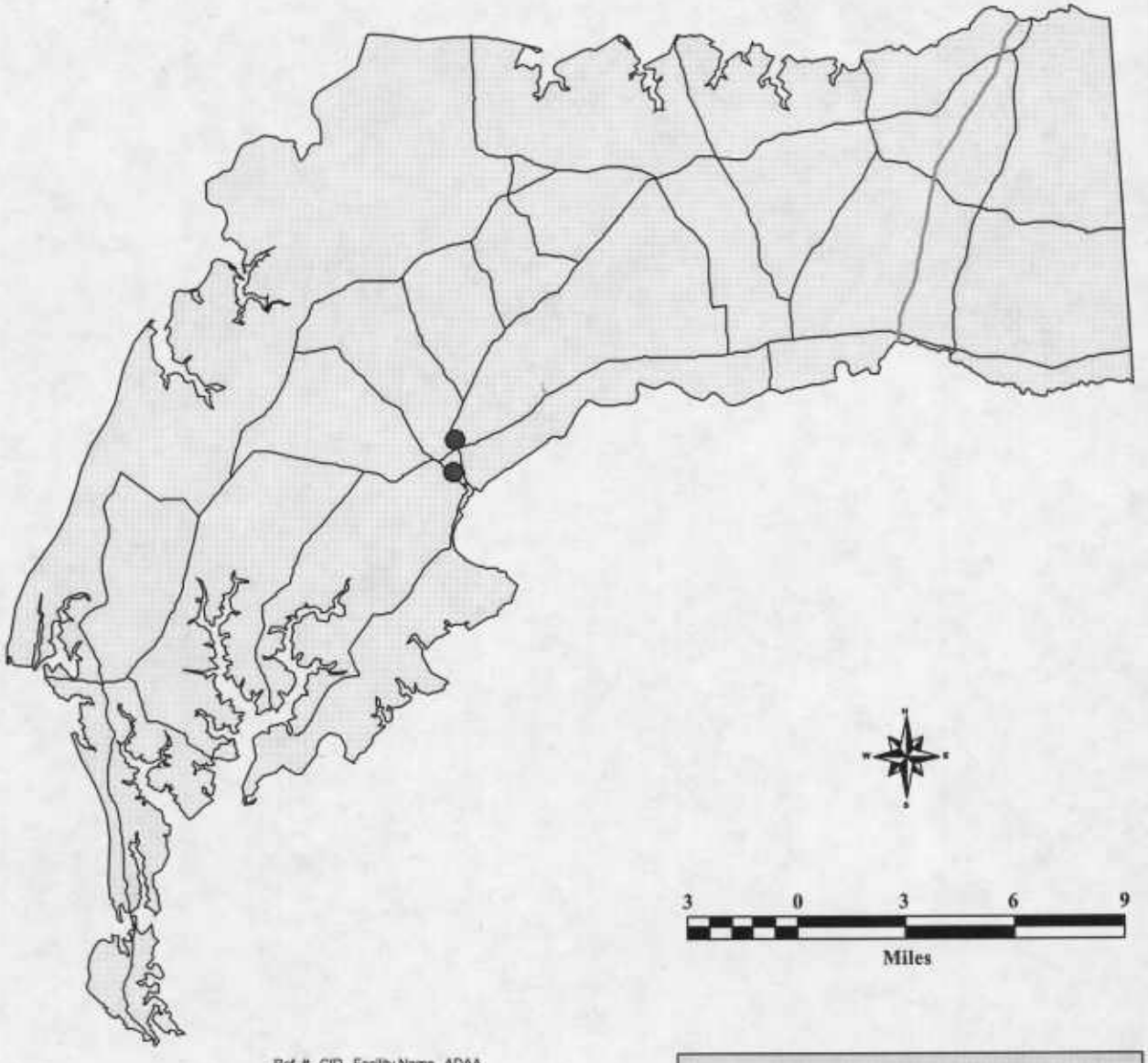
Harford County



Ref. #	CID	Facility Name	ADAA
1	100331	TRW ASSOCIATES	N
2	102105	ASHLEY - OP	N
3	102501	EMMORTON TREATMENT PROGRAM	N
4	104168	S.A.F.E. ASSOCIATES, INC.	N
5	104283	JOPPA HEALTH SERVICES, INC.	N
6	301640	ASHLEY	N
7	750283	MANN HOUSE	Y
8	900193	HARFORD CO. DRUG ABUSE PROGRAM	Y
9	903817	HARFORD CHD - OUTPATIENT	Y


Howard County Drug Treatment Programs
By ADAA Funding
ADAA Funding (1)
No ADAA Funding(9)

Kent County



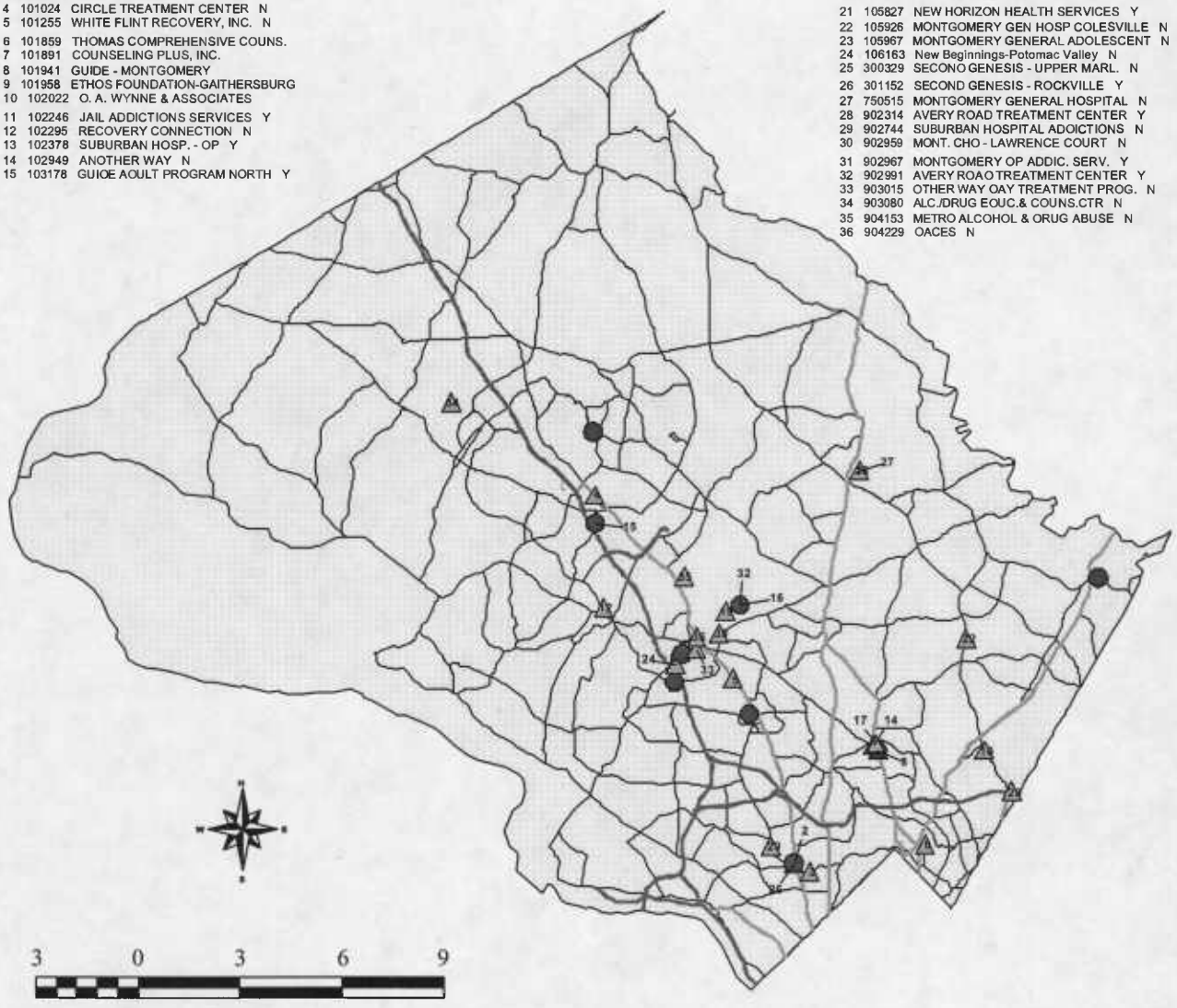
Ref. #	CID	Facility Name	ADAA
1	301293	KENT CHD - PUBLICK HOUSE	Y
2	902678	WHITSITT CENTER	Y

Kent County Drug Treatment Programs
By ADAA Funding

ADAA Funding (2)
No ADAA Funding(0)

Montgomery County

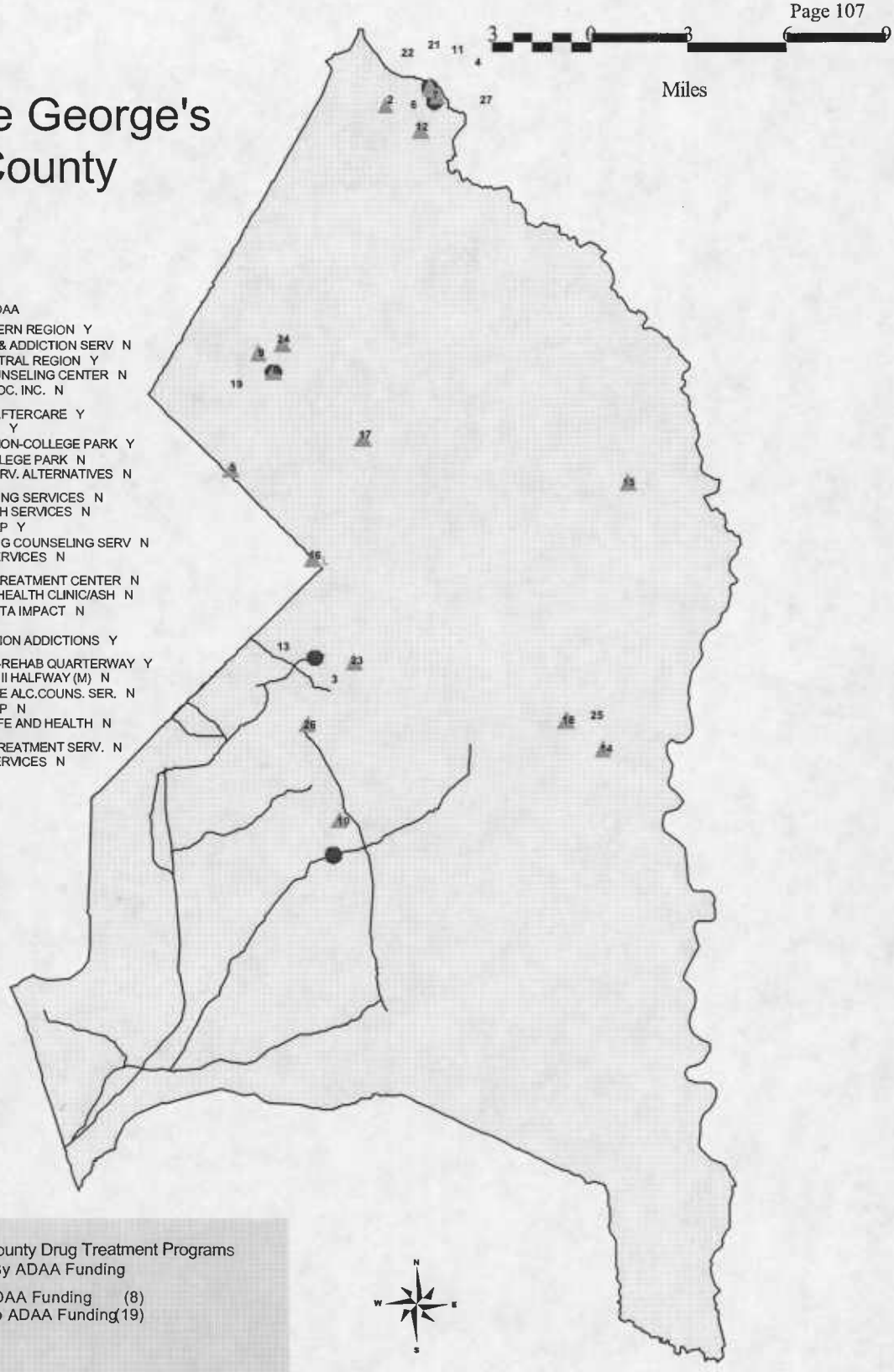
Ref. #	CID	Facility Name	ADAA
1	100851	GUIDE PROGRAM	Y
2	100885	SECONO GENESIS	Y
3	101016	COUNSELING INSTITUTE	N
4	101024	CIRCLE TREATMENT CENTER	N
5	101255	WHITE FLINT RECOVERY, INC.	N
6	101859	THOMAS COMPREHENSIVE COUNS.	
7	101891	COUNSELING PLUS, INC.	
8	101941	GUIDE - MONTGOMERY	
9	101958	ETHOS FOUNDATION-GAITHERSBURG	
10	102022	O. A. WYNNE & ASSOCIATES	
11	102246	JAIL ADDICTIONS SERVICES	Y
12	102295	RECOVERY CONNECTION	N
13	102378	SUBURBAN HOSP. - OP	Y
14	102949	ANOTHER WAY	N
15	103178	GUIOE AOULT PROGRAM NORTH	Y
16	103392	AVERY HOUSE FOR MOTHERS/CHILO	Y
17	103707	BILINGUAL COUNSELING CENTER	N
18	104077	OUTPATIENT AODICTION TRT SERVS	N
19	104275	MONTGOMERY RECOVERY SERVS	N
20	105207	SECONO GENESIS OP AOOL & FAM	N
21	105827	NEW HORIZON HEALTH SERVICES	Y
22	105926	MONTGOMERY GEN HOSP COLESVILLE	N
23	105967	MONTGOMERY GENERAL ADOLESCENT	N
24	106163	New Beginnings-Potomac Valley	N
25	300329	SECONO GENESIS - UPPER MARL.	N
26	301152	SECOND GENESIS - ROCKVILLE	Y
27	750515	MONTGOMERY GENERAL HOSPITAL	N
28	902314	AVERY ROAD TREATMENT CENTER	Y
29	902744	SUBURBAN HOSPITAL ADOICTIONS	N
30	902959	MONT. CHO - LAWRENCE COURT	N
31	902967	MONTGOMERY OP ADDIC. SERV.	Y
32	902991	AVERY ROAO TREATMENT CENTER	Y
33	903015	OTHER WAY OAY TREATMENT PROG.	N
34	903080	ALC./DRUG EOUC.& COUNS.CTR	N
35	904153	METRO ALCOHOL & ORUG ABUSE	N
36	904229	OACES	N



Montgomery County Drug Treatment Programs
By ADAA Funding

ADAA Funding (13)
No ADAA Funding(23)

Prince George's County



Ref. #	CID	Facility Name	ADAA
1	100141	PG CHD - NORTHERN REGION	Y
2	100638	MENTAL HEALTH & ADDICTION SERV	N
3	100711	ADDICTIONS CENTRAL REGION	Y
4	100869	FLYNN/LANG COUNSELING CENTER	N
5	100984	C.A. MAYO & ASSOC. INC.	N
6	101040	REALITY HOUSE AFTERCARE	Y
7	101917	REALITY INC: TRR	Y
8	101966	ETHOS FOUNDATION-COLLEGE PARK	Y
9	102014	UNIV. OF MD. COLLEGE PARK	N
10	102204	COUNSELING SERV. ALTERNATIVES	N
11	102675	ACT II COUNSELING SERVICES	N
12	102931	WE CARE HEALTH SERVICES	N
13	103160	P.G. COUNTY-CAP	Y
14	104234	ANOTHER SPRING COUNSELING SERV	N
15	104242	COUNSELING SERVICES	N
16	104804	RENAISSANCE TREATMENT CENTER	N
17	105199	AWELE SOCIAL HEALTH CLINIC/ASH	N
18	106064	PG COUNTY HIDTA IMPACT	N
19	106262	DRUGENSIC	N
20	300030	SOUTHERN REGION ADDICTIONS	Y
21	750499	REALITY HOUSE-REHAB QUARTERWAY	Y
22	902280	REALITY HOUSE II HALFWAY (M)	N
23	903858	COMPREHENSIVE ALC.COUNS. SER.	N
24	903940	UNIVERSITY ASAP	N
25	904047	INSTITUTE OF LIFE AND HEALTH	N
26	904120	AARS INSIGHT TREATMENT SERV.	N
27	904211	COUNSELING SERVICES	N

Prince George's County Drug Treatment Programs
By ADAA Funding

● ADAA Funding (8)
▲ No ADAA Funding (19)

February, 2001

Queen Anne's County

Miles

Ref. #	CID	Facility Name	ADAA
1	750325	QUEEN ANNE'S CHD - OUTPATIENT	Y

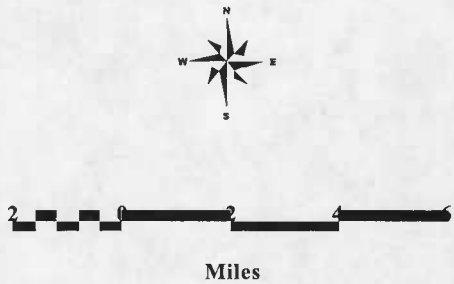
Queen Anne's County Drug Treatment Programs
By ADAA Funding

ADAA Funding (1)
No ADAA Funding(0)

February, 2001

Somerset County

Ref. #	CID	Facility Name	ADAA
1	103608	SOMERSET COUNTY DETENTION CTR.	N
2	901860	SOMERSET CHD ADDICTION SERV.	Y



Somerset County Drug Treatment Programs
By ADAA Funding

ADAA Funding (1)
No ADAA Funding (1)

February, 2001

St. Mary's County

Ref. #	CID	Facility Nama	ADAA
1	101123	MARCEY HALFWAY HOUSE	Y
2	105876	CERTIFIED COUNSELING SERVS,INC	N
3	901779	WALDEN COUNSELING CENTER	Y
4	901852	SIERRA HOUSE	Y

Miles

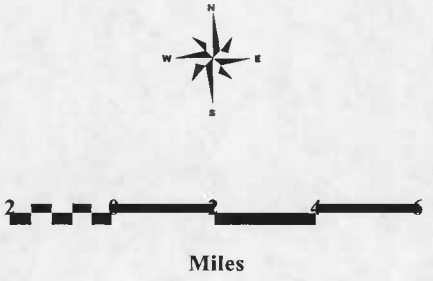
St. Mary's County Drug Treatment Programs
By ADAA Funding

ADAA Funding (3)
No ADAA Funding(1)

February, 2001

Talbot County

Ref. #	CID	Facility Name	ADAA
1	750390	TALBOT CHD - OUTPATIENT	Y



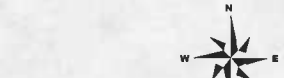
Talbot County Drug Treatment Programs
By ADAA Funding

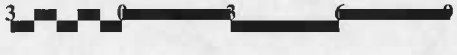
ADAA Funding (1)
No ADAA Funding(0)

February, 2001

Worcester County

Ref. #	CID	Facility Name	ADAA
1	901845	WORCESTER CHD ADDICTIONS	Y





Miles

Worcester County Drug Treatment Programs
By ADAA Funding

ADAA Funding (1)
No ADAA Funding(0)

February, 2001

Appendix F

Appendix G

Appendix H

November 22, 2000

The Association of
Maryland Hospitals
&
Health Systems

The Honorable Kathleen Kennedy Townsend
Lt. Governor/Chair, Task Force to Study Increasing the
Availability of Substance Abuse Programs
State House, 2nd Floor
Annapolis, Maryland 21401-1991

The Honorable Dan K. Morhaim, M.D.
Maryland House of Delegates/Vice Chair, Task Force to
Study Increasing the Availability of Substance Abuse Programs
304 Lowe House Office Building
Annapolis, Maryland 21401-1991

Dear Lt. Governor Townsend and Delegate Morhaim:

On behalf of the 68 members of MHA: the Association of Maryland Hospitals and Health Systems, this letter is written to provide comments on the *Draft Recommendations of the Maryland Drug Treatment Task Force Report*. We again want to commend you and the members of the task force for focusing significant time and attention to the issues surrounding substance abuse treatment services in Maryland.

With addiction and its side effects costing Maryland approximately $5.5 billion a year, the evidence is clear that drug treatment is a wise investment for government and society. Expanding access to effective drug treatment services will reduce drug use, crime, welfare dependence, child welfare and health care costs, and increase employment.

Funding for Additional Treatment

Similar to the findings contained in the task force's *Interim Report*, hospitals have concluded that there is a significant lack of available treatment programs for the uninsured and under insured in Maryland. Public-funded treatment programs across the state are filled to capacity, and thousands seeking treatment are turned away each year. Not surprisingly, insufficient funding is the primary reason for this lack of treatment capacity. The system is reimbursement driven, and capacity is driven by the availability of dollars.

We, therefore, strongly support and endorse the draft recommendation calling for the investment of significant additional funding into the drug treatment system over the next ten years.

6820 Deerpath Road
Elkridge, Marryland
21075-6234
410-379-6200
Fax 410-379-8239

On-Site Hospital Emergency Department Intervention

Hospitals see the consequences of drug abuse firsthand every day, as those addicted to drugs, as well as the victims of crimes associated with drug addiction, seek care in hospital emergency departments. According to a recent Drug Enforcement Agency report, for the first six months of the year, 159 of every 100,000 residents entered a Baltimore emergency room for a heroin-related overdose or medical condition.

For hospitals, the most critical problem for caring for those in need of substance abuse treatment has three critical aspects:

First is the undue burden which substance abusers, who are often uninsured, place on the resources of hospitals emergency departments when using them as their source of primary medical care. Second, this same group also consumes significant hospital inpatient resources for the treatment of chronic diseases associated with substance abuse. And, finally, there often are no available treatment programs to which an individual can be referred for appropriate follow up substance abuse treatment once the acute care needs of the patient are addressed.

Given the significant interface between hospitals and those in need of substance abuse treatment services, we strongly urge the task force to recommend the creation of a mechanism to target a portion of additional state funding for the immediate placement into substance abuse treatment programs for appropriately identified patients who present in hospital emergency departments.

Attached is a flow chart providing greater detail on this proposal, but, in essence, the approach entails:

- Placing a part-time addictions counselor in the hospital emergency department(s) during peak periods that correspond to peak usage by substance abusers.

- Having an addictions counselor administer an assessment tool that measures addiction severity, medical risk, and treatment readiness on those uninsured individuals identified with a substance abuse diagnosis.

- Assuring that uninsured patients, identified as appropriate for referral for substanceabuse treatment services, are contacted the next working day by a case manager who would develop a care coordination treatment plan.

  The care coordination treatment plan would facilitate the delivery of substance abuse treatment services, and create a linkage with a medical home for primary medical care, including treatment of other substance abuse-related illnesses.

- Developing an evaluation component to determine the effectiveness of the program.

We believe funding for creation of the identification and coordination mechanism outlined above will help ensure that additional public funding for substance abuse treatment is a wise and cost-effective investment. Implementation of this model is likely to result in:

1. Enhanced likelihood of treatment success;

2. Reductions in hospital uncompensated care associated with hospital emergency department visits and acute care admissions of uninsured substance abusers; and,

3. Transitioning substance abusers from uninsured status to employment and/or benefits programs.

In addition, there are several initiatives currently underway designed to enhance the delivery of primary care services to uninsured individuals that could be maximized under this approach.

The Reverse Referral Program currently funded by the Maryland Health Care Foundation and operating at Bayview Medical Center in conjunction with Baltimore Medical Systems and the consortium of three communities, in partnership with the Baltimore City Health Department, engaged in a planning process funded by the Robert Wood Johnson Communities in Charge Initiative are examples of two programs designed to improve the coordination of care to the uninsured. In both of these projects, substance abusers will be identified early in the episode of care and be linked to primary care resources. The approach outlined above could build on these and other similar projects by creating the necessary linkages between resources for substance abuse treatment services and other forms of social and medical support.

Further, we believe this model facilitates the development of a full continuum of care that supports community-based coordination and collaboration between providers—across programs, between levels of treatment, and with other medical and social services organizations and agencies.

We are in the process of preparing a budget detailing the costs associated with the creation and implementation of the on-site hospital emergency department intervention program. And, we would respectfully request the opportunity to present those details at the Availability Subcommittee's December 13 meeting.

Thank you for the opportunity to share these recommendations with you. We hope they prove useful in the work of the task force. If I can be of further assistance, or you would like to further discuss this proposal, please contact me.

Sincerely,

Pegeen A. Townsend
Sr. Vice President, Legislative Policy

Attachment
cc: Jenny Collier

Appendix I

DRUG AND ALCOHOL ABUSE TREATMENT BUDGET ALLOCATIONS FOR CRIMINAL JUSTICE POPULATIONS

Tracking the funding streams for the drug and alcohol treatment of criminal justice clients is a difficult task, because funding originates at the federal, state and local level. This report marks the first time these figures have been compiled to provide an assessment of how much is spent on this population for drug and alcohol treatment. The following provides a description of funding sources, the amount of funding, the agency receiving the funding, and the program that is funded. Bear in mind that some programs are funded by two separate sources, and the proportion of monies coming from each source may not be equal. Throughout this report, proportional funding breakdowns are provided in these instances.

I. BALTIMORE CITY

Baltimore City is the only jurisdiction that has Alcohol and Drug Abuse Administration (ADAA) funds "set aside" from its budget to treat criminal justice offenders for drug and alcohol abuse. There are three primary funding streams in Baltimore City: 35% of the Federal and State Substance Abuse Block Grant, the Correctional Options Program (COP I), and the Coerced Abstinence Seamless System (CASS).

A. 35% of the Block Grant

Baltimore City allocates 35% of its Substance Abuse Block Grant, used for substance abuse treatment services, to treat the criminal justice population. Funding for this grant originates from both the State General Fund (56.62% of the grant) and Federal funds (43.38%). It is appropriated by the Alcohol and Drug Abuse Administration (ADAA) to the Baltimore City Health Department (BCHD), who in turn awards the grant to Baltimore Substance Abuse Systems (BSAS). This specific percentage is used because in 1997, when this set-aside was initiated, approximately 35% of all individuals treated for drug and alcohol abuse came from criminal justice referrals. Twenty-eight treatment providers participate in this initiative, representing a variety of treatment modalities. Slots funded by the 35% set aside are available only to adults who have been referred by the Division of Parole and Probation and have drug and alcohol treatment as a special condition of their probation or parole. All other criminal justice referrals, such as the Drunk Driver Monitoring Program, pre-trial service, and voluntary referrals, are treated by facilities which have slots supported by the remaining 65% of the block grant. Further, Drug Treatment Court and Correction Options Program clients also may access 35% set-aside slots if the modality required for treatment is unavailable within COP I or CASS. In FY 2000, there were approximately 1,500 criminal justice clients served by programs funded by the 35% set aside, while slots supported by the remaining 65% of the block grant served 3,604 clients.

Total FY 2001 funding for 35% Block Grant set-aside: $5,694,561

B. COP I

COP I is a grant given to BSAS via the Baltimore City Health Department from the Department of Public Safety and Correctional Services. The program provides intensive outpatient treatment to those clients in both the Drug Treatment Court and the Correctional Options Program. These initiatives, designed to provide alternatives to incarceration for non-violent offenders, allow scarce prison and jail resources to be used those offenders who

present the biggest threat to public safety. In FY 2000, there were 759 offenders treated under the COP I system.

Total FY 2001 funding for COP I: $590,000

C. COP II/CASS

The Coerced Abstinence Seamless System (CASS), or COP II, is an annual grant given to BSAS from the Alcohol and Drug Abuse Administration. Clients in both the Drug Treatment Court and COP who require various treatment modalities are treated through this funding stream. The four basic therapeutic environments comprising this system are halfway house/transitional living, methadone maintenance, intermediate residential care facilities, and residential modified therapeutic community. Also, the women's Addicts Changing Together program of the Baltimore City Detention Center is funded through the CASS initiative. In FY 2000, there were 619 clients treated through the CASS/COP II program.

Total FY 2001 funding for COP II/CASS: $1,584,009

II. FEDERAL PROGRAMS

Residential Substance Abuse Treatment for State Prisoners Program (RSAT)

The Department of Public Safety receives both state and federal funding for the RSAT program. This grant program assists state and local governments with substance abuse programs for individuals in correctional and detention facilities. Inmates who are assessed by personnel and identified as having either a substance abuse history or problem are eligible for the program. Treatment lasts at least six months and is administered at the Central Laundry Facility or the Maryland Correctional Institute for Women. After residential treatment is completed, clients are referred to a community-based outpatient center, which generally lasts an additional six months. 75% of the funding for this initiative comes from federal funding, while the Alcohol and Drug Abuse Administration (ADAA) matches the remaining 25%. During FY 2000, the RSAT Program in Maryland admitted 698 men and 47 women.

Total FY 2001 Federal funding for RSAT: $1,200,000
Total FY 2001 ADAA funding for RSAT: $350,951
Total FY 2001 RSAT funding: $1,550,951

III. JAIL SUBSTANCE ABUSE PROGRAMS (JSAP)

A. Washington County JSAP

Washington County receives funding from ADAA to support its Jail Substance Abuse Program (JSAP). Initiated in 1989, JSAP allows inmates of local correction facilities to receive intensive substance abuse treatment. Inmates who have been assessed as needing substance abuse treatment are placed in a six-week intensive in-jail treatment program that is followed by nine months of community-based aftercare. Washington County's JSAP has received favorable evaluations and widespread recognition, leading it to serve as a model for

similar programs in both the State of Maryland and the nation. Approximately 150 individuals per year participate in this program.

Total FY 2001 funding for Washington County JSAP from ADAA: $215,662

B. Other Maryland County JSAP Initiatives

Seven counties, Allegany, Calvert, Carroll, Dorchester, Garrett, Prince Georges, and Somerset receive assistance from ADAA. Five of the seven counties, Allegany, Carroll, Dorchester, Garrett and Somerset originally developed their respective programs using Byrne Memorial Grant funds through the Governor's Office of Crime Control and Prevention (GOCCP). In addition to receiving this funding, these jurisdictions were required to match 25% of their Byrne Grant. However, Byrne Grant funding only lasts three years. Since these programs proved to be valuable in meeting the treatment needs of the incarcerated population, funding for these programs has been continued by ADAA provided that each jurisdiction continues to contribute their 25% match. Prince Georges County and Calvert County also receive funding from ADAA, but are not required to provide a local match. These two counties did not begin their programs through a Byrne Memorial Grant, but through a direct request to ADAA. Although these funding arrangements for these two jurisdictions have been continued, ADAA requires that all new requests for JSAP funding be directed through GOCCP. The amount of clients served each year by these programs are as follows: Allegany, 100; Calvert, 58; Carroll, 70; Dorchester, 160; Garrett, 36; Prince Georges, 140; Somerset, 40.

Total FY 2001 local match for counties receiving Byrne Grant pickup funding from ADAA: $116,980
Total FY 2001 funding for local Maryland County JSAPs from ADAA: $752,321

IV. DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES PROGRAMS

A. Division Parole and Probation

The Department of Public Safety and Correctional Services allocates money to the Division of Parole and Probation (DPP) for urinalysis and treatment for all probation and parole clients in the State. This funding originates from the State General Fund, which is comprised of State income tax and other revenues.

The Division of Parole and Probation conducts urinalysis testing at three sites throughout Baltimore City. This testing is used to monitor, track and measure offender treatment compliance. It also helps to determine when sanctions are necessary. There are various programs and initiatives in the State that use urinalysis testing as a measure of compliance, such as COP, Drug Court, and Break the Cycle. Approximately 20,200 offenders are tested annually.

The remainder of the money the Department of Public Safety and Correctional Services allocates to DPP is used for treatment. It covers staffing expenditures such as salaries for addictions counselors and assessors. In FY 2000, DPP assessed 11,128 offenders for criminal justice-specific drug and alcohol treatment programs. An additional 6,530 were referred to community-based treatment programs.

Total FY 2001 funding for DPP from DPSCS – Urinalysis Testing: $1,900,000
Total FY 2001 funding for DPP from DPSCS – Treatment Services: $2,600,000
Total FY 2001 funding for DPP from DPSCS: $4,500,000

B. Women's Intensive Treatment Program (WIT)

Using monies from the State General Fund, the Department of Public Safety allocates funds to the Women's Intensive Treatment Program (WIT) at the Maryland Correctional Institution for Women. This intensive, nine-month substance abuse treatment program serves approximately 75 women per year. The program allows women in prison to enter intensive treatment when they have three years remaining on their sentences, as opposed to treatment during their final year. This exception allows those women needing more intensive treatment to benefit more from programs that are geared towards inmates who are soon to be released.

Total FY 2001 funding for WIT from DPSCS: $248,000

C. Home Detention Program

State General Funds also are used by the Department of Public Safety to support a drug and alcohol treatment program within the Home Detention Unit. Since offenders who are in the community may be exposed to an atmosphere that permits drug use, prevention and treatment for this specific population is necessary. The Home Detention Unit offers a three-step program with graduated levels of intensity. During FY 2000, 1,162 clients participated in this program. Funding for this program is used to support two contractual addictions counselors.

Total FY 2001 funding for Home Detention Unit Drug and Alcohol Treatment Program from DPSCS: $55,000

D. Men's Addicts Changing Together Program (ACT)

Like the above programs, State General Funds are allocated to the Department of Public Safety and Correctional Services to fund the Men's Addicts Changing Together Program (ACT). ACT was established in 1996 at the Baltimore City Detention Center. The majority of clients treated within ACT are probationers or parolees. Programs for both male and female offenders exist; however, due to the size of the male program, it receives a separate allocation from the Department of Public Safety and Correctional Services. This 30-60 day program has three major components: detoxification, counseling, and education. Upon release, a community-based aftercare plan is developed for program graduates. ACT has been evaluated favorably, leading to the expansion of the program. Approximately 348 men participate in this program each year.

Total FY 2001 funding for the Men's Addicts Changing Together Program from DPSCS: $367,000

V. HIGH-INTENSITY DRUG TRAFFICKING AREA (HIDTA) PROGRAMS

The Office of National Drug Control Policy allocates funding to the Baltimore-Washington HIDTA to support local jurisdictional treatment services. Six jurisdictions, Baltimore City, Baltimore County, Charles County, Howard County, Montgomery County, and Prince Georges County, receive this type of funding. The majority of this funding supports addictions treatment personnel. However, some money is used for therapeutic community and residential outpatient services, and urinalysis.

Total FY 2001 funding allocated from ONDCP to HIDTA for local jurisdictions: $1,286,044

VI. GOVERNOR'S OFFICE OF CRIME CONTROL AND PREVENTION (GOCCP) PROGRAMS

A. Hotspot Addiction Recovery Programs*

The GOCCP allots Byrne Memorial Grant funding to a number of counties for their respective Hotspot Addictions Recovery Programs. These programs provide various services to county residents who are recovering addicts. Services include community outreach, assessments and referrals, training in money management and employment skills, family education and counseling, and random drug and alcohol testing. Funding is also used to help pay the salaries of counselors and staff for these programs. Counties that receive this funding include: Anne Arundel, Baltimore, Calvert, Charles, Howard, Montgomery, Queen Anne's, St. Mary's, Talbot, Wicomico, and Worchester. Only one county, Baltimore County, is required to provide a local funding match. (For a breakdown of how much funding is allotted to each individual county, please reference the accompanying chart).

Total FY 2001 Byrne Memorial Grant funding allocated from GOCCP to Maryland Counties for Hotspot Addictions Recovery Programs: $189,542
Total FY 2001 local match for Baltimore County's Hotspot Addiction Recovery Program: $9,288
Total FY 2001 funding: $198,830

B. Baltimore County Comprehensive Substance Abuse Services for Women*

Byrne Memorial Grant dollars are allocated to the GOCCP to support the Comprehensive Substance Abuse Services for Women Program at the Baltimore County Detention Center. A local match by the Baltimore County government is required for this grant. This program's intention is to provide substance abuse treatment to three incarcerated female populations at the detention center. These three populations are pre-sentencing inmates, pre-release inmates, and sentenced inmates. Treatment services include

* The number of participants in these programs was not able to be calculated in time for publication of the final report.

consultation, education, and referral to in-depth evaluation and treatment. Inmates who receive services through this program are required to sign an agreement to ensure that they will participate in a continuum of care that lasts for at least one year.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Baltimore County Health Department for the Comprehensive Substance Abuse Services for Women Program at the Baltimore City Detention Center: $66,584
Total FY 2001 local match for Baltimore County $22,194
Total FY 2001 funding: $88,778

C. Harford County Drug Treatment Court *

Byrne Memorial Grant dollars are appropriated by the GOCCP to support the Harford County Drug Treatment Court. A local match by the Harford County government also is required for this specific grant. This program is a partnership between the Harford County District Court and Health Department. Clients who are accepted into the program are referred to an intensive outpatient program, which entails treatment, urinalysis, and Division of Probation and Parole supervision. Clients must also regularly report to a District Court Judge.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Harford County Drug Treatment Court: $88,116
Total FY 2001 local match for Harford County: $25,663
Total FY 2001 Funding: $113,778

D. Harford County Relapse Avoidance Program

Harford County also receives Byrne Memorial Grant funding from the GOCCP for their Relapse Avoidance Program. A local match by the Harford County government is required for this grant. Clients are referred to this 52-week intense program by the Circuit Court prior to conviction. Program aspects include random urinalysis, treatment, counseling, vocational assistance, life skills training and relapse prevention regarding substance abuse. Approximately 30 offenders participate in this program each year.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Harford County Relapse Avoidance Program: $50,000
Total FY 2001 local match for Harford County: $12,500
Total FY 2001 funding: $62,500

E. Somerset County Incentive Program for Incarcerated Offenders ("Chance to Change") *

Somerset County receives Byrne Memorial Grant funding from the GOCCP for the "Chance to Change" program. Focusing on drug and alcohol treatment for incarcerated

clients, this program is a joint effort between the Somerset County Circuit Court and the Health Department. Clients are provided the opportunity to have their sentences modified after successfully completing the program. After care and employment recovery are emphasized, and monthly evaluation meetings occur to ensure effective communication between all involved agencies (Division of Parole and Probation, above listed agencies). Tracking of released offenders is also an important component.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Somerset County Incentive Program for Incarcerated Offenders: $39,610

F. Frederick County Detention Center Substance Abuse Treatment Program and Acupuncture Enhancement

Byrne Memorial Grant funds are allocated by the GOCCP to the Frederick County Health Department for substance abuse treatment at the Frederick County Detention Center. This initiative has separate programs for men and women, with men participating in a 90-day therapeutic community program, and women participating in a six to eight month day treatment program. In addition to group, individual and family therapy programs, reintegration and aftercare for a minimum of six months after release are required. This program serves 280 clients annually.

The Frederick County Health Department also receives Byrne Memorial Grant assistance from the GOCCP to operate acupuncture treatment within the Detention Center's Substance Abuse Treatment Program. Treatment of this nature is administered three times a week by a licensed Acupuncturist. Additionally, a Health Aid assists the Acupuncturist, and records self-report effects from inmates before and after each treatment session. This program is new for FY 2001; therefore, the number of participants is unknown as of February 6, 2001.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Frederick County Health Department for the Detention Center Substance Abuse Treatment Program: $85,000
Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Frederick County Health Department for the Detention Center Substance Abuse Acupuncture Treatment Program: $72,104

G. Anne Arundel County Government Substance Treatment and Recovery (STAR) Program Enhancement

The Anne Arundel County Government receives Byrne Memorial Grant funds from the GOCCP for the Substance Treatment and Recovery Program (STAR). This six-week intensive outpatient program serves the incarcerated population of the Ordnance Road Detention Center. Program elements include drug-free life skills training, individual counseling sessions, family therapy, transition services, and participation in self-help groups, such as Narcotics Anonymous. In July 1999, an evaluation of the STAR program showed that STAR graduates had significantly lower rearrest rates than non-STAR participants during a six-month follow-up period. Approximately 210 clients participate in this program each year.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Anne Arundel STAR Program: $142,500

H. Cecil County Jail Addictions Services*

Byrne Memorial Grant funding is allocated by the GOCCP to support the Cecil County Jail Addiction Services Program. This program services inmates at both the Cecil County Community Adult Rehabilitation Center (CARC) and the Cecil County Detention Center (CCDC). CARC inmates receive treatment and aftercare services three times a week, while CCDC inmates receive these services five times a week. Further, a mental health education component has been added to the program for CCDC clients in response to the prevalence of co-occurring disorders in this population. Both programs are of utmost importance in this jurisdiction, since very limited treatment services were available to the target population prior to the program's implementation.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Cecil County Jail Addictions Services Program: $80,000

I. Talbot County Jail Based Substance Abuse Addictions Program

The Talbot County Health Department receives Byrne Memorial Grant funding appropriated by GOCCP for the Substance Abuse Treatment Program at the Talbot County Detention Center. This program is a collaborative effort between the Talbot County Addictions Program, Detention Center, and Division of Parole and Probation. The goal of the initiative is to promote public health and safety by providing inmates the skills necessary to return to a drug-free life in the community upon release. This goal is realized by providing a "seamless system" of services from intensive treatment through aftercare. This program is new for FY 2001; therefore, the number of participants is unknown as of February 6, 2001.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Talbot County Jail Based Substance Abuse Addictions Program: $40,000

J. Project Challenge-Wicomico County*

The Wicomico County Health Department receives Byrne Memorial Grant funding from GOCCP for "Project Challenge" an alcohol and other drug treatment initiative for inmates. This intensive program consists of screening, assessment, and individual and group counseling. Treatment is administered throughout the inmates' entire sentence, and inmates are monitored upon release. This monitoring is intended to not only increase treatment compliance, but also to reduce recidivism.

Total FY 2001 Byrne Memorial Grant funding allocated by GOCCP to the Wicomico County Health Department for Project Challenge: $83,513

VII. DEPARTMENT OF JUVENILE JUSTICE PROGRAMS (DJJ)

A. Juvenile Drug Court-Baltimore City

Both State General Funds and funds from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) support the Baltimore City Juvenile Drug Court. This program is based on a coerced abstinence model, which entails providing treatment services and administering sanctions when juveniles are not compliant with treatment. Attorneys and counselors are also given smaller caseloads, so that treatment is more intense and consequences for non-compliance are more swift and certain. This program has the capacity to serve 200 male youths per year.

Total FY 2001 funding allocated by OJJDP to DJJ for the Baltimore City Juvenile Drug Court: $399,997
Total FY 2001 funding allocated from State General Funds to DJJ for the Baltimore City Juvenile Drug Court: $922,643
Total FY 2001 Baltimore City Juvenile Drug Court Funding: $1,322,640

B. Talbot County/Wicomico County Juvenile Drug Courts

Juvenile drug court programs also operate in Talbot and Wicomico Counties. These two programs are solely supported by State General Funds, and operate under the same philosophy as the Baltimore City Juvenile Drug Court. Both courts have the capacity to serve 50 male and female youths per year.

Total FY 2001 funding allocated from State General Funds to the Talbot County Juvenile Drug Court: $92,330
Total FY 2001 funding allocated from State General Funds to the Wicomico County Juvenile Drug Court: $101,519
Total FY 2001 Eastern Shore Juvenile Drug Court Funding: $193,849

C. Intensive Case Management – Heroin Addiction Project* *

D. Juvenile Justice Break the Cycle

State General Funds are allocated to DJJ to provide support for the Break the Cycle initiative for adolescent offenders. Specifically, Montgomery and Baltimore Counties receive funding for this initiative. The majority of this funding is used to pay addictions counselors' salaries, so that counselor caseloads can be reduced. This initiative is intended to provide 150 slots at any given time in each county.

Total FY 2001 funding allocated by DJJ to Montgomery and Baltimore Counties for Break the Cycle: $1,454,072

** Program description was not able to be obtained for the final report draft.

E. Contractual Residential Facilities

Three private facilities are under contract with the DJJ to provide residential treatment for male adolescents. These facilities are licensed or certified by the DJJ, and are annually monitored to ensure they comply with federal and State regulations. The Victor Cullen Center is a secure commitment facility located in Frederick County. This facility has the capacity to treat 184 males at one time, and the average length of stay is six months. The Charles H. Hickey, Jr. School in Baltimore County serves as both a detention center and training center, accepting both youth awaiting trial and youth committed by the court. This facility has 300 slots, with length of stay varying with the adolescent's sentence. The O'Farrell Youth Center in Carroll County is a secure facility that treats adolescent drug dealers and juveniles who have committed crimes against persons and property. It has 40 slots, with length of stay averaging nine months.

Total FY 2001 funding allocated by DJJ to the Victor Cullen Center: $1,364,885
Total FY 2001 funding allocated by DJJ to the Charles H. Hickey School: $2,355,000
Total FY 2001 funding allocated by DJJ to the O'Farrell Youth Center: $379,470
Total FY 2001 Funding: $4,099,355

F. Per Diem Placements

State General Funds and federal funds are allocated to the Department of Juvenile Justice to support treatment for DJJ involved clients in three private facilities. The three facilities are the Jackson Unit in Allegany County, Mountain Manor in Baltimore City, and Pathways treatment center in Annapolis.

Total FY 2001 funding allocated from the State General Fund to DJJ to support these three private facilities: $2,101,491
Total FY 2001 funding allocated by the U.S. Department of Health and Human Services to DJJ to support these three private facilities: $750,000
Total FY 2001 Funding: $2,857,491

G. Per Diem Co-Funded

State General Funds are allocated to DJJ for the purpose of supporting treatment in private facilities that accept Medicaid clients. The only facility that falls into this category is Mountain Manor in Baltimore City.

Total FY 2001 funding allocated from State General Funds to Mountain Manor: $333,760

H. Meadow Mountain Youth Center

Both State General Funds and funding from the ADAA and the GOCCP are given to DJJ to support the Meadow Mountain Youth Center. Located in Garret County, this facility treats approximate 120 juveniles per year.

Total FY 2001 funding allocated from State General Funds to DJJ: $598,832
Total FY 2001 funding allocated by ADAA to DJJ: $152,337
Total FY 2001 funding allocated by GOCCP to DJJ: $126,694
Total FY 2001 Funding: $877,863

I. William Donald Schaefer House

DJJ receives State General Funds to support the William Donald Schaefer House. This facility provides treatment for 14 to 18 year old boys that have a history of drug and alcohol abuse. An aspect of the treatment is preparing juveniles for independent living. In addition, youth are enrolled in community treatment programs upon release. This facility has 19 slots at one time, and the average length of stay is 90 days.

Total FY 2001 funding allocated from State General Funds to DJJ: $935,508

J. Other Department of Juvenile Justice funding for Drug and Alcohol Treatment

Both State and Federal funds are used to support various other program costs for juvenile drug and alcohol treatment. State funding originates from the State General Fund, while federal funding passes through ADAA and GOCCP.

Total FY 2001 funding allocated from ADAA to DJJ for General Substance Abuse Treatment Services: $820,663
Total FY 2001 funding allocated from State General Funds to DJJ for General Substance Abuse Treatment Services: $621,972
Total FY 2001 Funding: $1,442,635

Appendix J

Appendix J

SENATE BILL 71

Unofficial Copy 2001 Regular Session
J2 1lr0063

(PRE-FILED)

By: **Chairman, Economic and Environmental Affairs Committee**
(Departmental - Health and Mental Hygiene)
Requested: November 14, 2000
Introduced and read first time: January 10, 2001
Assigned to: Economic and Environmental Affairs

A BILL ENTITLED

AN ACT concerning

Alcohol and Drug Administration - Certification and Licensure Requirements - Alcohol and Drug Counseling

FOR the purpose of altering certain waiver provisions that apply to certification as a certified professional counselor-alcohol and drug, a certified associate counselor-alcohol and drug, or a certified supervised counselor-alcohol and drug; authorizing an individual to work as a trainee under certain circumstances; clarifying certain provisions relating to prohibited acts related to the practice of alcohol and drug counseling and clinical alcohol and drug counseling; and generally relating to the practice of alcohol and drug counseling and clinical alcohol and drug counseling.

BY adding to
Article - Health Occupations
Section 17-301(d)
Annotated Code of Maryland
(2000 Replacement Volume)

BY repealing and reenacting, with amendments,
Article - Health Occupations
Section 17-306(c) and 17-3A-11(a)
Annotated Code of Maryland
(2000 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health Occupations

17-301.

(D) (I) AN INDIVIDUAL MAY PRACTICE ALCOHOL AND DRUG COUNSELING WITHOUT CERTIFICATION FOR A LIMITED PERIOD OF TIME, AS DETERMINED BY THE BOARD, IF THE INDIVIDUAL IS WORKING AS A TRAINEE UNDER THE SUPERVISION OF A CERTIFIED PROFESSIONAL COUNSELOR-ALCOHOL AND DRUG, A LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR, OR ANOTHER HEALTH CARE PROVIDER LICENSED UNDER THIS ARTICLE AND APPROVED BY THE BOARD WHILE FULFILLING THE EXPERIENTIAL OR COURSE OF STUDY REQUIREMENTS UNDER § 17-302.3, § 17-302.4, § 17-302.5, OR § 17-3A-02 OF THIS TITLE.

(2) AN INDIVIDUAL MAY PRACTICE CLINICAL ALCOHOL AND DRUG COUNSELING WITHOUT A LICENSE FOR A LIMITED PERIOD OF TIME, AS DETERMINED BY THE BOARD, IF THE INDIVIDUAL IS WORKING AS A TRAINEE UNDER THE SUPERVISION OF A LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR OR ANOTHER HEALTH CARE PROVIDER CERTIFIED OR LICENSED UNDER THIS ARTICLE AND APPROVED BY THE BOARD WHILE FULFILLING THE EXPERIENTIAL OR COURSE OF STUDY REQUIREMENTS UNDER § 17-302.3, § 17-302.4, § 17-302.5, OR § 17-3A-02 OF THIS TITLE.

17-306.

(c) (I) The Board shall waive the requirements for certification as a certified professional counselor-alcohol and drug under § 17-302.3 of this subtitle for any person who:

(i) Has filed a letter of intent with the Board by [July 1, 1998] OCTOBER 1, 2001;

(ii) Holds a master's or doctoral degree in a health and human services counseling field or has completed a program that the Board determines to be substantially equivalent in subject matter and extent of training as a master's or doctoral degree in a health and human services counseling field;

(iii) As of July 1, [1997] 2001, is certified as a certified chemical dependency counselor, its equivalent, or higher by the Maryland Addiction Counselor Certification Board, another state, the Certification Commission of the National Association of Alcoholism and Drug Abuse Counselors, or the International Certification Reciprocity Consortium, or is employed in the capacity of a Program Specialist I, II, III, or its equivalent, or higher, [if the person is employed by the State, a political subdivision of the State, or an entity that provides alcohol and drug counseling services under contract with the State or a political subdivision of the State] IN AN AGENCY OR FACILITY ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS OR CERTIFIED UNDER TITLE 8, SUBTITLE 4 OF THE HEALTH - GENERAL ARTICLE;

(iv) Has completed not less than 3 years with a minimum of 3,000 hours of supervised experience in alcohol and drug abuse counseling approved by the

Board, 2 years of which shall have been completed after the award of the master's or doctoral degree; and

(v) Has, by [July] OCTOBER 1, 2001, successfully passed an examination approved by the Board.

(2) The Board shall waive the requirements for certification as a certified associate counselor-alcohol and drug for any person who has filed a letter of intent with the Board by [July 1, 1998] OCTOBER 1, 2001 if:

(i) The person holds a bachelor's degree in a health or human services counseling field or has completed a program that the Board determines to be substantially equivalent in subject matter and extent of training to a bachelor's degree in a health or human services counseling field;

(ii) The person, as of July 1, [1997] 2001, is certified as a certified chemical dependency counselor, its equivalent, or higher, by the Maryland Addiction Counselor Certification Board, another state, the Certification Commission of the National Association of Alcoholism and Drug Abuse Counselors, or the International Certification Reciprocity Consortium, or is employed in the capacity of a Program Specialist I, II, III, or its equivalent, or higher, [if the person is employed by the State, a political subdivision of the State, or an entity that provides alcohol and drug counseling services under contract with the State or a political subdivision of the State] IN AN AGENCY OR FACILITY ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS OR CERTIFIED UNDER TITLE 8, SUBTITLE 4 OF THE HEALTH - GENERAL ARTICLE; and

(iii) The person has completed not less than 3 years with a minimum of 3,000 hours of supervised experience in alcohol and drug abuse counseling approved by the Board, 2 years of which shall have been completed after the award of the bachelor's degree or a program that the Board determines to be substantially equivalent in subject matter and extent of training.

(3) The Board shall waive the requirements for certification as a certified supervised counselor-alcohol and drug for any person who has filed a letter of intent with the Board by [July 1, 1998] OCTOBER 1, 2001 if:

(i) The person holds an associate's degree in health or human services counseling or has completed a program that the Board determines to be substantially equivalent in subject matter and extent of training to an associate's degree in health or human services counseling; or

(ii) The person, as of July 1, [1997] 2001, is certified as a certified alcoholism counselor, certified drug counselor, or higher, by the Maryland Addiction Counselor Certification Board, another state, the Certification Commission of the National Association of Alcoholism and Drug Abuse Counselors, or the International Certification Reciprocity Consortium, or is employed in the capacity of an Addiction Counselor II or III, or its equivalent, or higher, [if the person is employed by the State, a political subdivision of the State, or an entity that provides alcohol and drug counseling services under contract with the State or a political subdivision of the

State] IN AN AGENCY OR FACILITY ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS OR CERTIFIED UNDER TITLE 8, SUBTITLE 4 OF THE HEALTH - GENERAL ARTICLE.

17-3A-11.

(a) (1) Except as otherwise provided in paragraph (2) of this subsection, an individual may not practice, attempt to practice, or offer to practice clinical alcohol and drug counseling, clinical marriage and family therapy, or clinical professional counseling in the State unless licensed by the Board.

(2) Subject to the rules and regulations of the Board, paragraph (1) of this subsection does not apply to:

(i) A student working under the supervision of a licensed mental health care provider while pursuing a supervised course of study in counseling that the Board approves as qualifying training and experience under this title; [or]

(ii) An individual with a graduate degree in counseling or a related field who is working under the supervision of a mental health care provider duly licensed under this article for the purpose of qualifying for a license under this title; OR

(III) AN INDIVIDUAL WHO, IN ACCORDANCE WITH § 17-301(D) OF THIS TITLE, IS WORKING AS A TRAINEE UNDER THE SUPERVISION OF A LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR OR ANOTHER HEALTH CARE PROVIDER CERTIFIED OR LICENSED UNDER THIS ARTICLE AND APPROVED BY THE BOARD WHILE FULFILLING THE EXPERIENTIAL OR COURSE OF STUDY REQUIREMENTS UNDER § 17-302.3, § 17-302.4, § 17-302.5, OR § 17-3A-02 OF THIS TITLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2001.